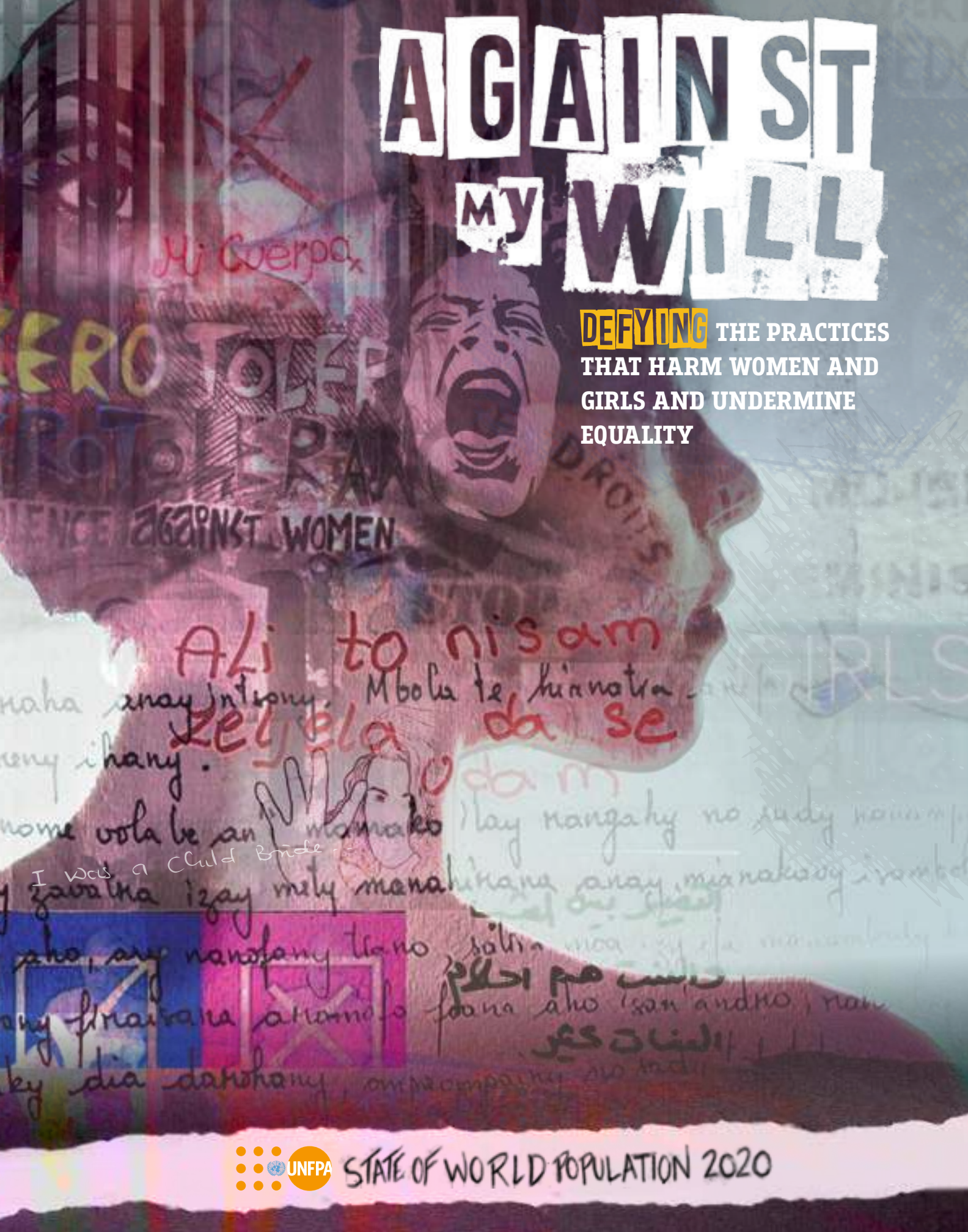
AGAINST MY WILL
DEFYING THE PRACTICES THAT HARM WOMEN AND GIRLS AND UNDERMINE EQUALITY
Mi Cuerpo
ZERO TOLERANCE
TOLERANCE
VIOLENCE AGAINST WOMEN
Ali to nisam
Zelela da se
I was a Child Bride
UNFPA
STATE OF WORLD POPULATION 2020

State of World Population 2020

This report was developed under the auspices of the UNFPA Division of Communications and Strategic Partnerships.

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ACKNOWLEDGMENTS
UNFPA thanks the following people for sharing glimpses of their lives for this report:
Janoghlan Ilyasov (Azerbaijan); Arelis Cortés (Colombia); Randa Diaa, Dr. Hania Sholkamy (Egypt); Abebech Kabla, Boge Porre (Ethiopia); Jasbeer Kaur, Mandeep Kaur, Pardeep Kaur, Sandeep Kaur (India); Suci Maesaroh (Indonesia); Youngsook Cho, Dr. Eun Ha Chang, Kyung-Jin Oh (Republic of Korea); Rhobi Samwelly (Tanzania); Angeli Gajadhar, Brenda Gopeesingh, Dr. Gabrielle Hosein, Dr. Peter Douglas Weller, Kevin Liverpool, Marcus Kisson (Trinidad and Tobago); Sherry Johnson, Donna Pollard, Sara Tasneem (USA).

UNFPA colleagues and others around the world supported the development of feature stories and other content or provided technical guidance: Kamran Aliyev, Liliana Arias, Esther Bayliss, Nilanjana Bose, Shobana Boyle, May El Sallab, Ingrid Fitzgerald, Rose Marie Gad, Abraham Gelew, Celeste Hibbert, Sina Jones, Diego Muñoz, Meron Negash, Lucky Putra, Dalia Rabie, Aurora Noguera-Ramkissoon, Samidjo, Casey Swegman, Jeanne Smoot and Bright Warren.

UNFPA also thanks the women and girls around the world who shared their thoughts and hand-drawn images expressing views and experiences as survivors of harmful practices. These expressions appear throughout the report.

The editors are grateful to the Population and Development Branch of UNFPA for aggregated regional data in the indicators section of this report. Source data for the report's indicators were provided by the Population Division of the United Nations Department of Economic and Social Affairs, the United Nations Educational, Scientific and Cultural Organization, UNICEF, and the World Health Organization.

Susan Guthridge-Gould provided invaluable writing and editing services, and Scriptoria communications services reviewed proofs and reconciled citations and references.

MAPS AND DESIGNATIONS
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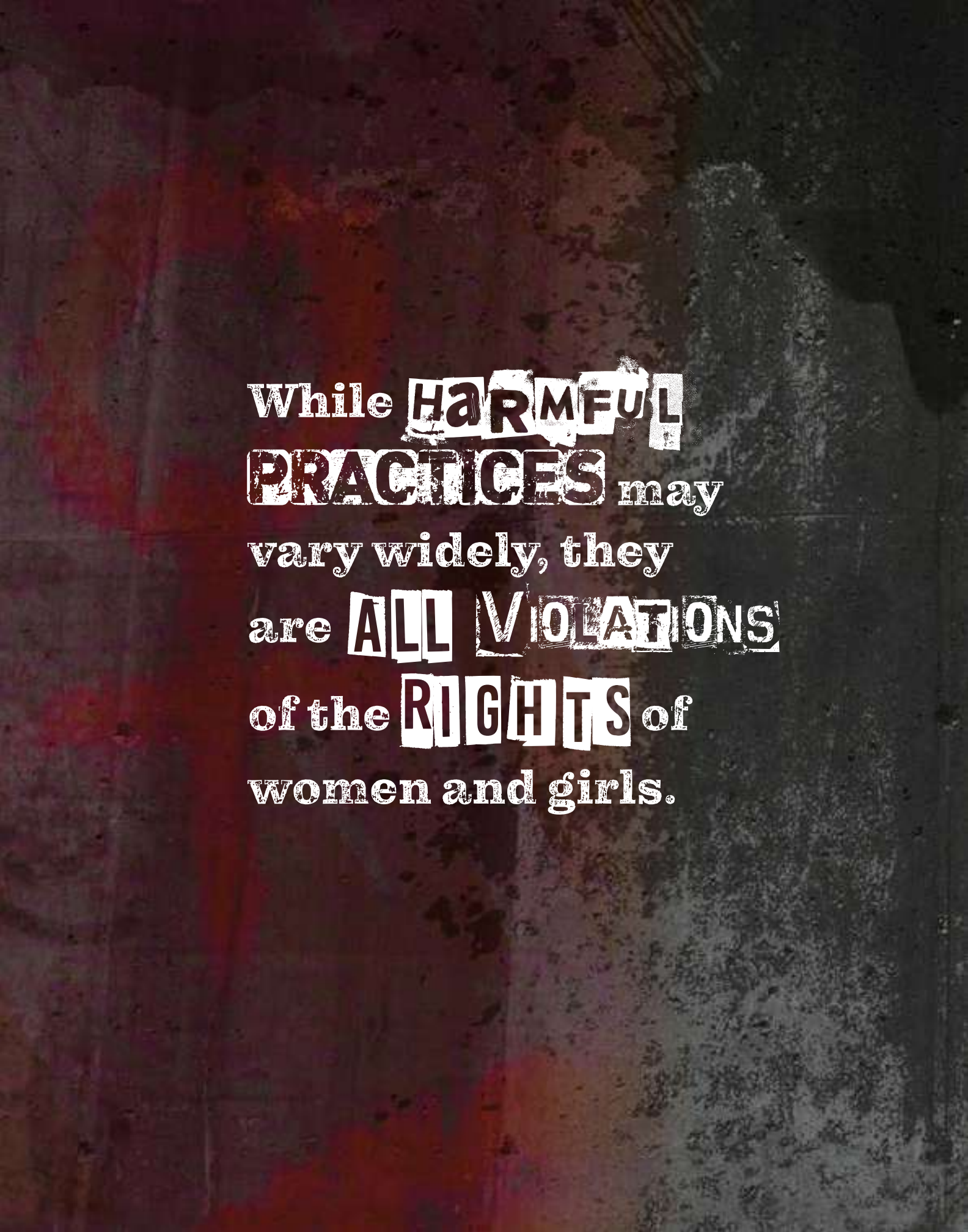
UNFPA

ENSURING RIGHTS AND CHOICES FOR ALL

UNFPA STATE OF WORLD POPULATION 2020

AGAINST MY WILL

DEFYING THE PRACTICES THAT HARM WOMEN AND GIRLS AND UNDERMINE EQUALITY


While HARMFUL PRACTICES may vary widely, they are ALL VIOLATIONS of the RIGHTS of women and girls.

CONTENTS

TAKE ACTION

END the Harm

Every day, tens of thousands of girls have their health, rights and futures stolen. Some are subjected to female genital mutilation. Some are forced into "marriages" as children, and still others are neglected or starved, simply because they are female.

In many instances, parents who subject their daughters to harmful practices may do so with good intentions. They wrongly accept that female genital mutilation must factor into acceptance by peers in communities where this practice is widespread. They mistakenly believe that marrying off a child will secure her future. Some are unaware of the physical and psychological health risks.

Good intentions, however, mean little to the girl who must abandon school and her friends to be forcibly wed, or to the girl who faces a lifetime of health problems because of mutilation from a harmful rite of passage.

In 1994, at the International Conference on Population and Development, ICPD, world governments called for universal sexual and reproductive health and decisively demanded an end to harmful practices. One year later, at the Fourth World Conference on Women, governments again declared that harmful practices must stop.

Progress in slowing the rate of some adverse practices has been achieved, yet because of population growth, the number of girls subjected to harm is actually growing. Clearly, pledges and resolutions have not been sufficient to end harmful practices once and for all. What we need now are real change and real results.

Last year, at the Nairobi Summit on ICPD25, representatives from governments, grassroots organizations, development agencies and the private sector moved beyond pledges and resolutions and committed to ending the unmet need for contraceptives, ending preventable maternal death, and ending gender-based violence and harmful practices.

This year begins a "decade of action" to achieve the Sustainable Development Goals by 2030, including target 5.3 on ending harmful practices. To meet our objective and protect the millions of women and girls whose bodily integrity is threatened, now is the time to push harder. The pace of our progress must be faster.

Governments must meet their obligation to protect girls and women from harm. Human rights treaties, such as the Convention on the Rights of the Child, direct governments to "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of the children".

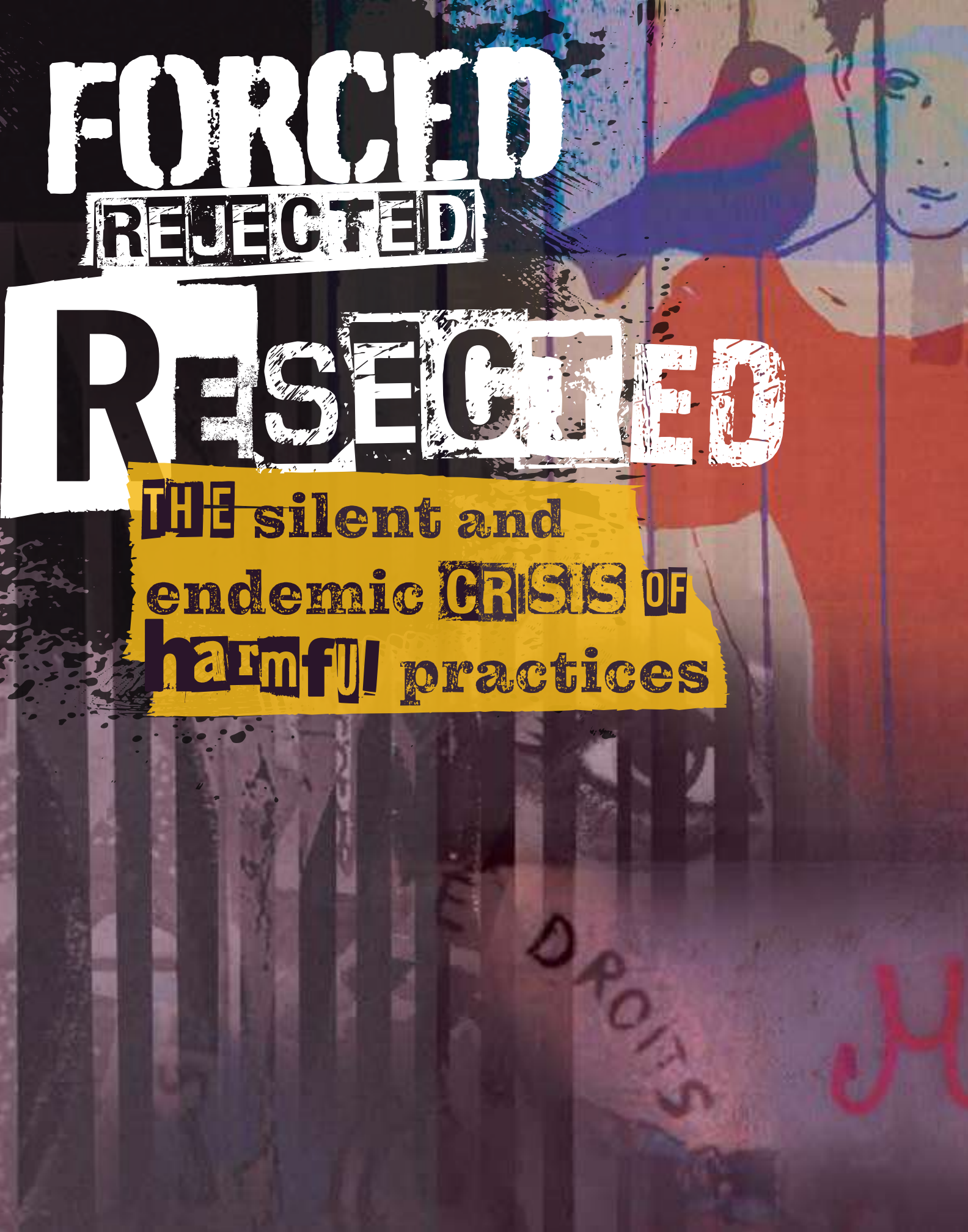
Getting to zero may prove difficult, yet I have no doubt it is achievable. After all, some harmful practices have persisted over centuries. Yet change will—and must—come. The first step in changing attitudes and social norms is educating parents about the consequences harmful practices have for their daughters and about the benefits that accrue to families and communities when girls are healthy and empowered, and their rights are respected. We know that actions that put women, men, girls and boys on an equal footing in all spheres in life can help transform long-standing traditions of harm. We know that dismantling patrilineal property and inheritance systems can also help dismantle the institution of child marriage. We know what works.

And we now also know what it would cost to end the two most common harmful practices, female genital mutilation and child marriage: a well-spent $3.4 billion a year, on average, from 2020 through 2030, to end the suffering of an estimated 84 million girls.

Armed with knowledge, backed by international human rights agreements, and buoyed by new commitments by governments and civil society, we have the power to defy the forces that perpetuate harm and to realize a world where every woman and girl is free to chart her own future.

As of early 2020, the world faces an unprecedented pandemic, with COVID-19 raging across the globe, taking lives and wreaking havoc on societies and economies. At this time of adversity, UNFPA will continue to protect the health and rights of women and girls in the countries and communities where we work.

Dr. Natalia Kanem
United Nations Under-Secretary-General and Executive Director of UNFPA, the United Nations Population Fund


FORCED
REJECTED
RESCUED
THE silent and endemic CRISIS OF harmful practices

She's a commodity to be traded.

She's an object of desire.

She's a burden to discard.

She's a source of free labour.

SHE'S a GIRL.

Which means that, despite her inherent human rights, her body, her life and her future are not her own.

We live in a world where so many dimensions of power and choice are still determined by gender. Most women and girls face some, if not many, discriminatory barriers to equality. Among the many causes and consequences of gender discrimination, harmful practices rank as some of the most insidious.

Such practices result in acute and often irreversible harm but may be accepted as normal, even beneficial. In many cases, they embed disempowerment and inequality at the very start of life—in the body and traumatized mind of an infant or adolescent girl. Into adulthood and throughout her life, they may deny her prospects to get an education, give birth safely, make a decent livelihood or speak up for her rights.

Child, early and forced marriages and female genital mutilation are among the most prominent examples of harmful practices that arise from the lack of power and rights among women and girls, and in turn deepen these deficits. With many variations, harmful practices are widespread and can be found in every region of the world, in both developing and developed countries. No country can claim to be entirely untouched by them. While some harmful practices, such as child marriage, may also affect boys, they are strongly concentrated among girls and women, affecting hundreds of millions.

Ending harmful practices by 2030 in every country and community—an objective of UNFPA, the United Nations sexual and reproductive health agency, and a key target of the Sustainable Development Goals—will require rapid changes in mindsets that still sanction violence against women and girls and deny their rights and bodily autonomy. Transformation is needed too in economic, education, legal, and health-care systems that intersect with these norms and continue to both reflect gender discrimination and perpetuate its lasting damage.

There are indications that members of a younger generation of girls, more aware of their rights, are rejecting harmful practices as never before (UNICEF, 2020). There is longstanding global agreement on ending them, and men and boys are increasingly challenging gender inequality and advocating changes that benefit everyone (Commission on the Status of Women, 2020).

A violation of rights

The scope of harmful practices is vast. Some operate on a national or regional scale, and even trace patterns of international migration. Others are hidden in isolated communities (Banda and Atansah, 2016). This report focuses on three harmful practices—female genital mutilation, child marriage and son preference—that have long been denounced in international human rights agreements as well as national constitutions and laws, and are strongly linked to sexual and reproductive health and rights. While harmful practices may vary widely, they are all violations of the rights of women and girls.

Such practices may be "explained" under the guise of tradition, religion or culture. They may even, on the surface, be well intentioned. The family of a girl may genuinely believe that marrying her at a young age will secure her financial future or protect her from sexual assault. Performing female genital mutilation may in fact ensure her acceptance as an adult within her community.

But all harmful practices come down to the assumption that the rights and well-being of

a woman or girl are less than those of men and boys. Women and girls have fewer choices as a result, and are more likely to have choices made for them that put them under the sexual, legal and economic control of men.

Multiple international human rights treaties and other agreements, signed by nearly all countries, require States to act to stop harmful practices. The Convention on the Elimination of All Forms of Discrimination against Women, for example, stipulates taking all appropriate measures to eliminate prejudices and practices based on gender discrimination. The Programme of Action of the 1994 International Conference on Population and Development explicitly recognizes female genital mutilation as a violation of basic rights that must be prohibited wherever it exists.

Harmful practices may be carried out by family members, religious communities, health-care providers, commercial enterprises or State institutions. Regardless of the source, governments are obligated to end such practices. Often, this means more than formally banning them by law, although that is an essential step. Achieving gender equality that is actually felt in the everyday lives of women and girls requires a series of steps to ensure freedom from harm and to transform all patterns of discrimination and unequal power relations between men and women.

Street art from Tegucigalpa, Honduras. Photo courtesy of Daniel Quesada-Rebolledo, Horizons of Friendship.

A mixed picture of progress

Some harmful practices that have received systematic attention in recent years, such as child marriage and female genital mutilation, are waning in countries where they have been most prevalent. Population growth, however, means that unless *prevalence rates* see a dramatic decline in the near future, a larger *number* of women and girls than ever before will endure such practices in the coming decades.

Mural painted by Fidel Évora in Largo Intendente, Lisboa, to help raise awareness against female genital mutilation. ©CML | DPC | José Vicente 2014

Insufficient rates of change and demographic pressures combine with a mixed picture of progress on gender equality globally. Despite strong advances towards gender parity in access to health care and education, acute discrimination and marginalization are still evident around the world.

In 57 countries, only 55 per cent of women aged 15 to 49 years who are married or in a union make their own decisions about sexual relations and the use of contraceptives and reproductive health services (UNFPA, 2020). By another recent estimate, it will take nearly 100 years, on

average, to close the overall global gender gap, and an astonishing 257 years to close the gender gap in terms of participation in the economy (World Economic Forum, 2020). Progress is greatly slowed by people's perceptions. One survey covering 80 per cent of the world's population found that 90 per cent of men—and women—have some kind of bias against women (UNDP, 2020).

The broader backdrop to gender discrimination is one of globally rising inequalities and intensifying exclusion. Operating across societies and entrenched by current economic models, these disparities fuel social divisions and tensions. They sustain and worsen gender inequalities, even as a deliberate pushback against gender equality is gaining ground.

Some regions have expanded restrictions on sexual and reproductive health and rights, and limit or have eliminated comprehensive sexuality education in schools (Commission on the Status of Women, 2020). Over 100 countries still legally prevent women from working in certain jobs (World Bank, 2018). Little has been done to moderate the growing influence of new technologies, which, while offering many benefits, have heightened the exposure of women and girls to the risk of violence and abuse (Commission on the Status of Women, 2020).

Harmful practices tend to track worsening pressures such as economic disparities and conflict, as well as mounting crises linked to climate change. Austerity measures can lead to cuts in public funds for health and other services that poor communities and low-income women in particular depend on. By 2021, approximately 5.8 billion people will be living in countries affected by austerity plans, including nearly 2.9 billion women and girls, or almost three quarters of the world's female population (Commission on the Status of Women, 2020).

A cascade of harm

A harmful practice may start as a one-off event. A girl's legs are forced open and parts of her genitals sliced off. A child bride dressed in fancy clothes numbly recites her marriage vows. Packed with pain and shock, that one moment, however, then spills into many more. A harmful practice becomes a cascade of harm.

Girls and women who are taught that their bodies exist primarily for the pleasure of, or control by, men are also less likely to know their rights. From a human rights perspective, the

It demands a society-wide effort, where everyone who has a role in stopping these practices **STEPS UP** to do so. And it must link the diverse drivers of harmful practices and women's disempowerment.

violations accrue on multiple fronts, denying rights to equality and non-discrimination, security and autonomy in decision-making. Also denied can be rights to sexual and reproductive health and education, and opportunities to work and thrive in life.

While some of these harms are difficult to measure empirically, they are nonetheless human rights violations because they arise from discriminatory gender norms that perpetuate inequality. And they are imposed on women and girls, regardless of consent.

The harm caused can be immediate and long-term, physical and psychological. A girl subjected to female genital mutilation at first faces severe pain and the risk of infection, haemorrhage and even death. Throughout her life, she may struggle with reproductive tract infections, chronic back pain, painful intercourse and a loss of sexual pleasure, and difficulties in childbirth, among many other possibilities. She will be more likely than a girl who has not been harmed this way to experience psychological illnesses, including post-traumatic stress disorder.

A girl forced into an early marriage will in many cases drop out of school, dashing prospects for later earnings and autonomy. She may find herself socially isolated and prone to depression. And unlike a boy in an early marriage, she may get pregnant whether she wants to or not, and before her body is ready, leading to a host of risks and consequences for her and her baby.

Where son preference, another harmful practice, operates, sex selection favouring boys may occur before birth, or later on may translate into shorter breastfeeding times for girls, poorer nutrition, inadequate schooling and fewer inoculations. By adulthood, this can leave women less equipped in terms of education, employment, political rights and family status.

Harmful practices have tragic consequences for individuals but also have wider ramifications. Child marriage is closely linked to higher levels of fertility and the perpetuation of poverty across generations. It undercuts the development of a productive, skilled workforce with a direct bearing on the health of an economy.

Son preference has led to gross imbalances in the number of men and women, so much so that large numbers of men may be unable to find

partners and have children. This may intensify the risk of violence against women, fuel human trafficking and increase women's vulnerabilities to other forms of harm (Kaur, 2013). But above all, son preference and its many manifestations perpetuate negative attitudes towards women and girls and in turn drive further harm.

Getting to zero

Gender equality is an agreed global goal under the 2030 Agenda for Sustainable Development, which also explicitly calls for ending all forms of discrimination, violence and harmful practices against all women and girls everywhere. In 2019, at the Nairobi Summit on ICPD25, held to mark the twenty-fifth anniversary of the International Conference on Population and Development, participants reiterated their commitment to strive for zero harmful practices. In 2020, the twenty-fifth anniversary of the 1995 Fourth World Conference on Women has lent new momentum to the global drive towards gender equality and women's empowerment, including through mobilizing an energetic, digitally native new generation of feminist advocates speaking out around the globe.

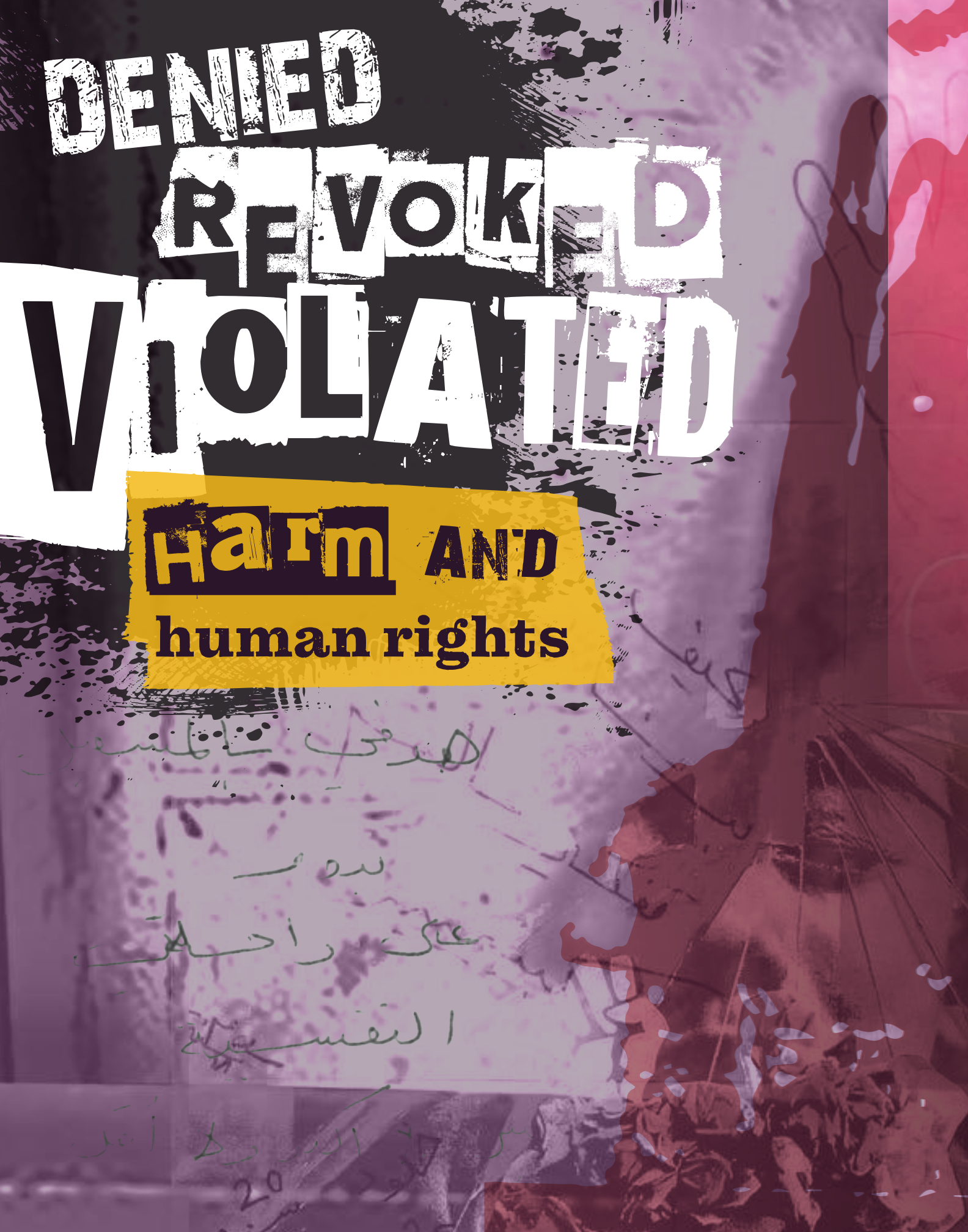
Harmful practices are part of a continuum of violence against women and girls that remains widespread and are a "silent and endemic crisis" (Commission on the Status of Women, 2020). One third of women will experience physical or sexual abuse at some point in their lives (Commission on the Status of Women, 2020). Despite steady improvement in laws and initiatives to curb violence and harmful practices, many forms are still not visible, not understood and not accepted as a problem. Trends such as the "medicalization" of female genital mutilation, where trained medical personnel perform the practice; cases of "selling" child brides on social media; and the use of reproductive health technology to enable discriminatory preferences for sons, are worrisome signs of how harmful practices, despite often ancient origins, are translating into the modern world.

Shifts in public opinion offer hope. While well-known social media movements have exploded a long-standing silence around sexual harassment and abuse, new research is finding that in countries affected by female genital mutilation seven in 10 girls and women think the practice should end. And opposition may be mounting, with some surveys finding adolescent girls at least 50 per cent more likely than older women to oppose the practice (UNICEF, 2020).

Getting to zero harmful practices will require much faster progress, however. It demands a society-wide effort, where everyone who has a role in stopping these practices steps up to do so. And it must link the diverse drivers of harmful practices and women's disempowerment. Communities must agree to protect their daughters. Girls must be able to stay in high-quality schools, learn about their rights and choices, and speak freely about their wants and needs. Public services must support the equal sharing of unpaid care and domestic work to shift gender discrimination in families. Economies must provide every woman with opportunities to build a decent life characterized by autonomy, dignity and choices.

DENIED
REVOKED
VIOLATED

Harm AND human rights



Every day, hundreds of thousands of **GIRLS around the world are harmed physically or psychologically,** with the full knowledge and consent of their families, friends and communities. Sometimes the harm involves mutilating their genitals, often rationalized as a rite of passage from childhood to womanhood. Sometimes it involves giving away, selling or trading a girl for money or an object of value, often in the name of "marriage". And other times, the harm is more insidious: a preference for sons over daughters, which reinforces negative attitudes about the value of women and girls in society and perpetuates gender inequality.

These diverse harmful practices have one thing in common: they are human rights violations.

The international community has come together over the years to agree that some harmful practices cannot be tolerated and that governments, communities and individuals have a duty to end them. Yet these practices persist around the world, even in places where national laws forbid them, and that means rights violations continue.

A deeper understanding of harm

The harmful practice—the act—that harms and violates a girl's body does not stop there, but causes additional harm by denying her ability to enjoy many other rights. The impact ripples throughout society and reinforces the very gender stereotypes and inequality behind the harm in the first place.

To international human rights experts, harm has a broad scope and meaning. It is more than an injury—physical, mental or emotional—that hurts a person. It is more than an economic injury that exacts a toll on earnings and savings, and it is more than a reputational injury that damages a person's standing in the community. These kinds of harm can be measured, but the harm from child marriage or son preference can extend far beyond the individual, and can be—in a word—immeasurable.

The United Nations holds that harmful practices often have the purpose or effect of "impairing the recognition, enjoyment and exercise of the human rights and fundamental freedoms of women and children", according to a number of international Conventions and Declarations.

Harmful practices have "a negative impact" on girls' "dignity, physical, psychosocial and moral integrity and development, participation, health, education and economic and social status", states a November 2014 General Comment by committees for the two key Conventions in this area: the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women—known as the ***Child Rights Convention*** and the ***Women's Convention***.

Discrimination is at the core. Harms to dignity are recognized as human rights violations because they are forms of discrimination that reduce and limit the capacity of women and children to participate fully in society or develop and reach their full potential.

And they have a lot in common. Harmful practices stem from social norms that perpetuate the dominance of men over women, boys over girls. They are about the inequality of women and children, based on sex, gender, age and other intersecting factors. Ultimately, they are imposed on women and children by family members, community members or society at large—regardless of consent.

Gender stereotypes are part of the harm. In human rights terms, they are harmful because they are based on "preconceptions about attributes or characteristics that are or ought to be possessed by, or the roles that are or should be performed by, women and men, which… limits their ability to develop their personal abilities, pursue their professional careers and

make choices about their lives and life plans" (Cusak, 2013).

Directly or indirectly, discriminatory violations arise because these practices prevent girls and women from exercising their human rights on a basis of equality with men and boys.

What all these practices have in common is an underlying belief in a fixed, categorical binary that divides men from women, and boys from girls, and prescribes hierarchical social roles and expectations, assigning more value and worth to men and boys, and thereby subordinating women and girls.

Families who subject their daughters, wives and mothers to harmful practices are often well intended. Governments, as part of their obligations to end harmful practices, have a duty to prevent family members from perpetrating harm, as well as to change social norms and attitudes that link a girl's destiny to marriage and reproduction.

Harmful practices violate a range of human rights related to equality, security of the person, health and autonomy in decision-making.

Practices recognized as human rights violations include female genital mutilation (FGM), child marriage and gender-biased sex selection, the causes and consequences of which are evidence of other human rights violations. Son preference, while not a human rights violation in itself, is a driver of harmful practices that are violations, such as gender-biased sex selection. Other practices around food and around menstrual taboos are also cause for concern among rights experts.

PRACTICES

considered **harmful** under international human rights treaties

- Accusations of witchcraft
- Binding, branding, scarring or infliction of tribal marks
- Body modifications, such as lip discs, neck elongation
- Breast ironing
- Bride price and dowry-related violence
- Child marriage
- Corporal punishment
- Crimes committed in the name of so-called honour
- Female genital mutilation
- Gender-biased sex selection
- Incest
- Infanticide
- Nutritional taboos and traditional birth practices
- Providing too little or too much food to girls
- Stoning
- Taboos or practices that prevent women from controlling their own fertility
- Violent initiation rites
- Virginity testing
- Widowhood practices

Human rights and the United Nations

The 1948 Universal Declaration of Human Rights establishes what governments today can and cannot do, as well as what they should do, for all people—without discrimination. All nations have endorsed the Universal Declaration of Human Rights, which expresses a common recognition of what human rights are, and why they should exist for all people everywhere, regardless of sex, gender, race or ethnic origin, colour, religion, nationality, language, disability, place of residence or any other status.

Human rights are often expressed and guaranteed by law, in the form of treaties, customary international law, general principles and other sources of international law. Customary law refers to the way nations behave towards each other whether or not a treaty is in place. It is a matter of deriving law from the observed behaviour of nations.

The "International Bill of Human Rights" is the name given to General Assembly resolution 217 (III), which ratified the Universal Declaration of Human Rights, and two international treaties established by the United Nations:

- The International Covenant on Economic, Social and Cultural Rights
- The International Covenant on Civil and Political Rights

In addition, human rights are elaborated or articulated in numerous other agreements:

- The International Convention on the Elimination of All Forms of Racial Discrimination
- The Convention on the Elimination of All Forms of Discrimination against Women
- The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- The Convention on the Rights of the Child
- The Convention on Migrant Workers and their Families
- The Convention on the Rights of Persons with Disabilities
- The Convention on Enforced Disappearances

Treaties are contracts between governments, or "States Parties". States Parties agree among each other on the terms, or articles, in treaties. When governments sign and ratify treaties, they become binding and require governments to uphold and implement the rights contained in the treaties.

All United Nations Member States have ratified at least one human rights treaty, obliging them to respect, protect and fulfil all human rights, as they are considered to be universal, interdependent and interrelated. One of the ways governments do this is by ensuring their national laws and policies are compatible with the rights obligations contained in treaties.

For each treaty, there is a "treaty body", a committee of independent experts who track nations' compliance, based on reports from States Parties, who are required to submit reports to treaty bodies every few years on progress made and obstacles encountered in fulfilling their obligations. The treaty bodies issue "Concluding Observations", which recommend actions countries should take to better meet their human rights obligations.

In addition, treaty bodies issue General Comments and General Recommendations, which help governments understand their obligations under the treaties and provide authoritative interpretation about a treaty's meaning. General Comments, Recommendations and Concluding Observations, however, do not force governments to act; rather, they give guidance to governments and are, increasingly, sources from which international customary norms, standards and law are being recognized.

Another important source of human rights norms comes from political consensus agreements, such as the Programme of Action of the 1994 International Conference on Population and Development in Cairo and the Platform for Action of the 1995 Fourth World Conference on Women in Beijing. These agreements, along with the United Nations Sustainable Development Goals, establish common global policies and targets for the realization of the rights of women and girls, including rights to sexual and reproductive health, and for the achievement of gender equality.

All appropriate measures

The Women's Convention and the Child Rights Convention explicitly address harmful practices and elaborate the obligations States have towards ending them.

The Women's Convention directs States to "take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women" and to "take all appropriate measures… to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women". All but seven governments have ratified or acceded to the Women's Convention.

The Child Rights Convention, which applies to anyone younger than 18, requires States to "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of the children". Health, as defined by the World Health Organization, is a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The Child

Mural by Andrea Fonseca Poder Femenino, Salamanca, Spain 2018

Rights Convention has been ratified by all but one of the United Nations Member States.

Gender equality, the right to be free from sex- and gender-based discrimination and to be treated equally, is widely recognized as a human right in the International Bill of Human Rights.

International human rights frameworks

Under the Convention on the Elimination of All Forms of Discrimination against Women, States Parties should:

- Take all appropriate measures to modify [such] social and cultural patterns of conduct…

Under the International Covenant on Economic, Social and Cultural Rights, States Parties should:

- Ensure that harmful social or traditional practices do not interfere with access to pre- and postnatal care and family planning
- Prevent third parties from coercing women to undergo traditional practices

Under the Convention on the Rights of the Child, States Parties should:

- Protect children from physical, sexual and mental violence, including from acts perpetrated by parents or other caregivers

Treaty bodies have called on States to:

- Undertake a range of effective social interventions to transform norms and support substantive gender equality and the rights of women and girls. These include long-term awareness-raising informational and educational campaigns aimed at community and religious leaders, family members, men and boys, as well as women and girls
- Use all the means at their disposal—budgetary, legislative, administrative, political—on their own and in conjunction with civil society, faith and community-based groups to eliminate the practice

Treaty bodies have also directed States Parties to comply with these obligations through law. For example, the joint General Comment on harmful practices (CEDAW 31/CRC 18; UN CEDAW and UN CRC, 2014) says that governments should:

- Adopt or amend legislation with a view to effectively addressing and eliminating harmful practices...[ensuring that such legislation] is in full compliance with the relevant obligations outlined in the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child and other international human rights standards.

HEALTH, as defined by the World Health Organization, is a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Respect, protect and fulfil

Human rights obligations are understood to require governments to respect, protect and fulfil the human rights of their populations. *Respect* means they cannot directly violate rights; *protect* means they have a duty to keep third parties from violating rights and to provide a process of redress for violations; and *fulfil* requires states to deliver the information and services necessary to realize all enumerated results (OHCHR, n.d.).

Because harmful practices often involve violence against girls and women, governments have an obligation to prevent, investigate and punish such acts, including when non-state actors, such as family members, perpetrate the violence (UN CEDAW, 2017, 1992).

Government obligations related to economic and social rights, such as health and education, are understood to take longer to fulfil because they require more time, resources and programming to be fully compliant. But civil and political rights, such as preventing discrimination and violence, are thought to be more easily and quickly addressed by passing or enforcing laws.

According to UN Women, all United Nations Member States include a provision in their constitution guaranteeing gender equality and non-discrimination in some domains, such as political participation (UN Women, n.d.). Rights to equality in marriage and family life are guaranteed in 181 constitutions; rights to freedom from violence in 182.

Laws are not enough

Legislation is the primary means for States to guarantee human rights. But while enacting laws and establishing rights in constitutions are necessary steps, they are far from sufficient to prevent and eliminate gender-based harmful practices. National laws prohibiting FGM, for example, exist in the majority of countries where the practice takes place, yet it continues (WHO, 2020). It is rarely due to the absence of laws that women and girls have their genitals cut, get forced into marriage, are fed far too much or too little, or are less desired as progeny.

Effective measures to prevent and eliminate harmful practices must be part of a "well-defined, rights-based and locally relevant holistic strategy", according to the treaty bodies that monitor adherence to the Women's Convention and the Child Rights Convention. The strategy should comprise laws, policies and social interventions "combined with commensurate political commitment and accountability at all levels".

At a minimum, States are obligated to collect, update and disseminate data on the incidence and prevalence of harmful practices; develop and apply "appropriate laws and regulations" with the participation of affected communities; and implement prevention efforts to establish rights-based social and cultural norms, empower women and communities through education and economic opportunity, raise awareness and manifest commitment, and ensure protective measures and responsive services are available to women and girls most vulnerable to harmful practices.

Female genital mutilation

Treaties

The list of human rights treaties and other agreements that address the wrongs of FGM is long. So too is the list of directives to State and non-State actors to end the practice.

According to human rights treaty bodies, FGM is a *gender-based* practice that targets women and girls in ways that directly diminish their ability to enjoy their human rights on an equal basis with men, thereby violating rights to non-discrimination and equality.

Further, the practice reflects discriminatory and stereotypical beliefs about female sexuality—that women and girls must be protected from it and be put under the control of men. The United Nations Special Rapporteur on violence against women, its causes and consequences described the practice as the "result of the patriarchal power structures that legitimize the need to control women's lives, arising from the stereotypical perception of women as the principal guardians of sexual morality, but with uncontrolled sexual urges".

FGM may entail cutting off a girl's clitoris and labia, suturing together what remains so that only a small aperture is left for urine and menstrual blood to escape. Because this practice involves surgical bodily alteration, a girl's *health* is of primary concern. Complications can include haemorrhage, infection, sepsis and death. Depression and long-term loss of sexual pleasure and sometimes function are common. Other long-term consequences include infertility, pain, scarring, urinary issues, and poor obstetric and neonatal outcomes (Nour, 2008). Treaties that explicitly cite health rights are the International Covenant on Economic, Social and Cultural Rights, the Women's Convention and the Child Rights Convention.

Male circumcision

In 1997, UNFPA, UNICEF and the World Health Organization issued a joint definition of female genital mutilation as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons" (WHO, 1997).

Do elements of this definition of FGM also apply to male circumcision? The Office of the High Commissioner for Human Rights says the two are false equivalents in that the "effect, intent, purpose and consequences associated with FGM are much more harmful", and that "female genital mutilation is often used to primarily control women's and girls' sexual desires, while male circumcision does not have this intent or result" (UN HRC, 2015).

Because some of the physical harm and health consequences from FGM stem from it being carried out in unsanitary conditions, parents sometimes turn to doctors, nurses or midwives, in the belief that if the procedure is "medicalized", or performed by a health-care professional in a sterile environment, it is less harmful. But United Nations treaty bodies, as well as groups such as the International Federation of Gynecology and Obstetrics and numerous national medical associations, have unequivocally rejected medicalization because there is never a medical reason for FGM and because agreeing to it would make health professionals complicit in human rights violations (UN HRC, 2015; Cook and others, 2002). Furthermore, there is no evidence that medicalized FGM carries a lower health risk.

What governments are obligated to do about it

The International Conference on Population and Development Programme of Action, endorsed by 179 governments in 1994, calls for governments to "urgently take steps to stop the practice of female genital cutting [mutilation] and protect women and girls from all such similar unnecessary and dangerous practices". It urges governments and communities to support:

- Community outreach programmes involving village and religious leaders, education and counselling about the impact of FGM on girls' and women's health
- Appropriate treatment and rehabilitation for girls and women who have suffered cutting
- Counselling for women and men to discourage the practice.

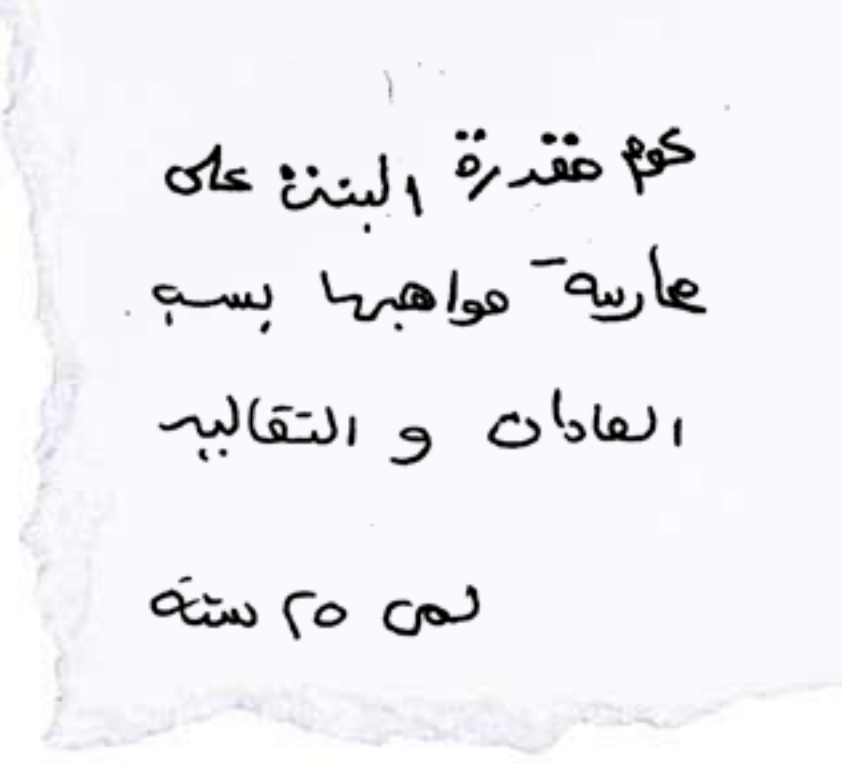
Artwork courtesy of Fatma Mahmoud Salama Raslan

Child marriage

Treaties

In 1948, the Universal Declaration of Human Rights stated that "men and women of full age… have the right to marry and to found a family" and that "marriage shall be entered into only with the free and full consent of the intending spouses". Eighteen years later, that language was echoed in the International Covenant on Civil and Political Rights. The right to marry free from coercion and force is also embodied in the Women's Convention.

Child marriage is also a violation of rights against gender stereotyping, to life and security of one's person, to protection from violence, to enjoy one's health and to education.



Girls are unable to fulfill their potential due to the norms and traditions.

Lama, 25 years old, Jordan

The right to marry: free and full consent

Any marriage entered into without free and full consent is forced and is always a human rights violation. Only individuals who have obtained the "age of majority" defined in national law, are considered to have the capacity to consent to marriage and some countries consider marriages null and void if entered into under this age. Under international agreements and in many countries, child marriage is considered to be *forced* insofar as a child under 18 is deemed to be incapable of consenting to marriage, in part due to the "important responsibilities" assumed in marriage and to ensure the attainment of "full maturity and capacity to act". Article 16 of the Women's Convention states that the betrothal and marriage of a child "shall have no legal effect" and calls on governments to take "all necessary action, including legislation" to specify a minimum age for marriage and to require that all legal marriages be officially registered with government offices.

Most nations, following the Child Rights Convention, establish a minimum age of consent to marriage at 18, although in some settings the minimum age is as low as 16 or as high as 21, sometimes depending on the sex of the individual (Pew Research Center, 2016).

Despite this, in more than half the world's nations, parental consent can override any age-related minimum (Arthur and others, 2018). Nonetheless, the international human rights consensus, articulated through nearly 60 years of United Nations treaty and charter

documents, agency reports and international political consensus agreements, is that marriage before the age of 18 is harmful and discriminatory and therefore a human rights violation (UN HRC, 2014).

In some circumstances, the Committee on the Rights of the Child recognizes an exception in the matter of close-in-age consenting unions, noting that a child's capacity to exercise autonomy in personal decision-making evolves over time and obliges States and parents to accord that child's decision due respect. It may be that an adolescent aged 16 or older has the desire and maturity to consent to marriage, but this determination should be made for each case by a competent authority.

Discrimination and stereotyping

Gender stereotyping and sex discrimination are the main reasons why girls, not boys, account for the majority of child marriages. Long-standing patriarchal notions about a girl's worth being linked to her virginity, ability to reproduce and ability to contribute domestic labour to the household mean that marriage is a way for men to control women and girls (WHO, 2018; Girls Not Brides, 2016). Research shows that girls who are married early are very likely to perpetuate traditional gender roles, to hold stereotypical notions and to transmit these norms to their own children (Asadullah and Wahhaj, 2019).

Fear of sexual violence and the stigma associated with it, because it "ruins" a girl's virginity, is one motivating factor for child marriage. The belief is that a girl will somehow be safe from rape if she is married. This belief is also a driver of other harmful practices, such as breast ironing,

CHILD MARRIAGE BANS ARE a victory

and a starting point

A 2017 law banning child marriage in Trinidad and Tobago was a hard-fought victory, decades in the making, says Angeli Gajadhar an activist with the Hindu Women's Organization, which spearheaded efforts to end the practice.

Before the law went into effect, girls as young as 12 could be married. "Men liked to say, 'After 12 is lunch.' For a long time, 12 meant you were an adult," Gajadhar says.

Efforts to end child marriage in the country began nearly 30 years ago but did not gain momentum until about four years ago, when a number of grassroots organizations joined forces and successfully advocated for a ban. Together, they "engaged in a true kind of cross-class, cross-race coalition, cross-country coalition to end child marriage," says Dr. Gabrielle Hosein, director of the Institute of Gender and Development Studies at the University of the West Indies.

Although the law is now in place, the work is far from over, advocates say.

Even before child marriage was banned, most such unions went unregistered: one government estimate showed that fewer than 1 per cent of formal marriages included a person aged 16 or younger. Yet informal, often sexually exploitative, relationships between girls and older men remain a widespread concern.

"That puts us in a very dangerous place because we have not transformed the norms that led to the child marriages taking place in the first place," says Hosein. "While we have abolished child marriage, we have not abolished predatory masculinity."

"The older men target young girls," Gajadhar adds. "They still get into common-law relationships, co-habitational relationships, visiting relationships."

Legislation is an important first step, explains Dr. Peter Douglas Weller, a clinical psychologist and co-founder of the Caribbean Male Action Network, CariMAN, which works with men and boys to advance gender equality. "Now we need to implement the law," Weller says, "and change the mindsets of the individuals who might engage in this practice."

"We talk about men as having power and privilege, and we need to harness that position if we want to make change," Weller says. "We need to have men resist and push back against the behaviour of their peers—ideally without them being then evicted from the group, because you want them in the group because you want them to continue being a positive influence."

But the barriers remain high. Kevin Liverpool, an activist with CariMAN, says he sees a backlash among men who see women's activism as a threat. "It's important to raise awareness among these groups, among these individuals, about what feminism is, why gender equality is important for women, but also for men and also for all of society," he says.

Hosein agrees that lasting change will be elusive "until men and boys, in their own conversations and in their own lives, are prepared to recognize that patriarchy and patriarchal gender relations still exist, and that

"While we have abolished CHILD MARRIAGE, we have not abolished predatory masculinity."

while they may benefit men, they also harm them as well as harming women."

Indeed, child marriage has exacted an intergenerational toll on men as well as women. "You have a lot of scarring, a lot of trauma that has been, that is experienced now, and has been carried for generations," Weller says. "We don't necessarily understand the emotional trauma that is caused when you're a boy growing up in a home where the mother that you care about is being abused by the father you also care about, and the cognitive dissonance that takes place."

Men need to "listen to the experiences of women, speak *with* women and not for women," says Marcus Kisson, who works on ending child sex abuse in Trinidad and Tobago. "Otherwise it's going to just be a legislative change and not a cultural change."

And Gajadhar points to the importance of making comprehensive sexuality education and reproductive health services available to young people. Comprehensive sexuality education not only empowers young people to prevent sexually transmitted infections and unintended pregnancies, it also communicates key messages about human rights, consent and maintaining respectful relationships.

Until women and girls are empowered stewards of their own reproductive health and decision-making, they will be vulnerable, says Hosein: "Women and girls' sexuality is the last frontier in their emancipation, in their rights and in their freedom from both male predation and from violence."

which disfigures a girl to make her less desirable to potential attackers (Obaji, 2020).

So paramount is female virginity to marriage that women and girls in many countries are subjected to virginity testing—an invasive vaginal examination to search for the hymen—the practice of which has been recognized as a human rights violation in itself (WHO, 2018).

Child marriage is associated with a girl's loss of rights to decision-making about her own life. Even where the law states a married girl should be treated as an adult, she must often seek her husband's permission to go to school, work outside the home or use contraception, in violation of her rights to non-discrimination and equality, education, employment, family planning and health.

Interrelated rights to life, health and education

Child marriage violates a girl's right to the highest attainable standard of health, as described in the International Covenant on Economic and Social Rights, the Women's Convention and the Child Rights Convention. For example, child marriage is associated with early, poorly spaced, repeated pregnancy and childbirth, and pregnancy-related deaths are the leading cause of mortality for girls between 15 and 19 years of age (WHO, 2019).

The Committee on the Elimination of Discrimination Against Women and the Committee Against Torture attribute physical, mental or sexual harm to early

When FOOD is used as a tool for harm

UNDERNUTRITION OF GIRLS

Poor nutrition undermines the capacity of children to grow and develop to their full potential. Globally, one in three children under the age of 5 is undernourished or overweight, and one in two suffers from "hidden hunger" such as deficiencies in vitamins and other essential nutrients (UNICEF, 2019).

Women and girls face numerous challenges related to their nutritional needs over their lifetimes. In childhood, the effects of malnutrition can be particularly harmful. Stunting and wasting can lead to poor growth, infection and death; challenges related to cognition, school readiness and school performance; and poor earning potential later in life. Micronutrient deficiencies can lead to poor growth and physical development, poor immunity, and poor health and risk of death. Obesity comes with its own set of challenges, including diabetes and other metabolic disorders, and cardiovascular disease (UNICEF, 2019).

In areas where preference for sons is most prevalent, young girls may be fed less, or given less favoured foods, than their brothers (Ramalingaswami and others, 1997; Chen and others, 1981). Data suggest, for example, that in some places where sons are favoured over daughters, girls are breastfed for shorter periods of time than their male counterparts. This is driven in large part by parents' desires to wean girls early so women can resume their menstrual cycle sooner, with the intention of becoming pregnant again, preferably with a boy (Jayachandran and Kuziemko, 2011).

FORCED FEEDING

While beliefs and practices in some parts of the world mean that girls go to bed hungry, in other places, girls are subjected to the opposite problem: forced feeding. Sometimes known as gavage or leblouh, the practice of force-feeding girls is linked to the cultural belief that overweight or obese women are more desirable for marriage. Indeed, since the practice is intended in part to help girls look older and ready for marriage, it has close ties to the practice of child marriage (Smith, 2009).

Anecdotal evidence indicates that girls and young women who are subjected to forced feeding are made to consume large quantities of high-calorie food. Girls may be directed in this practice at home, by mothers or grandmothers, or sent to force-feeding "camps" where groups of girls are overseen by a female elder for weeks or months, and directed in daily food consumption under the threat of violence.

While documentation of the practice is sparse, it is believed to have originated among some West African nomadic communities, where obesity in women was seen as a sign of beauty and prosperity, since the wives of rich men typically did not engage in physical labour (Ouldzeidoune and others, 2013).

TABOOS ABOUT FOOD

Food taboos, restrictions and prohibitions are practised all over the world. They are often meant to protect the well-being of individuals and may be perceived to aid in social cohesion, creating a sense of collective identity and belonging (Meyer-Rochow, 2009).

In some places, taboos about what foods are safe or dangerous during pregnancy and after giving birth can harm a woman and her baby (Piperata, 2008).

Such taboos imposed on pregnant women and lactating mothers have been linked to low birth weight, micronutrient deficiencies in children, and increased risk of maternal and neonatal death (Siega-Riz and others, 2009). Some taboos are driven by social inequities within communities, with men or other socially powerful groups declaring meat or other highly valued foods off-limits to others (Meyer-Rochow, 2009).

Like other harmful practices, food-related harmful practices are aspects of gender-based discrimination stemming from stereotyping, and governments have a duty "to modify [such] social and cultural patterns of conduct" according to Article 5(a) of the Women's Convention.

and child marriage. These United Nations bodies have documented consequences of child marriage that include self-harm by immolation or suicide; domestic violence, including physical and psychological violence; and acid attacks and murder (UN CRC, 2012, 2009; UN CAT, 2011; UN CEDAW, 2011, 2011a).

Child marriage also contributes to higher school dropout rates. Education is fundamental to the enjoyment of many rights and is especially associated with improved health and development outcomes (IPPF, 2006).

What governments are obligated to do about it

As child marriage stems from gender-based stereotyping and discrimination, States have a duty "to modify [such] social and cultural patterns of conduct" according to Article 5(a) of the Women's Convention.

Laws establishing 18 as the minimum age of marriage are important but are not by themselves sufficient to stop child marriage. Enforcement can be a challenge for reasons including exceptions when parental approval is granted, or when customary and religious laws are not directly aligned with national laws. Governments may therefore be better served by addressing underlying social, cultural and economic drivers of child marriage and by establishing accurate and accessible birth registry systems, so that ages can be verified and unlawful marriages voided (Girls Not Brides, n.d.).

Son preference

While there are many manifestations of son preference, one stark expression of it is through gender-biased sex selection, including the termination of fetuses determined to be female. By and large, gender-biased sex selection is motivated by negative gender stereotypes. The practice has emerged in countries with strongly patrilineal family structures, where married couples reside with or near the husband's family, combined with strong and persistent son preference and undervaluing of girls. Previously, women and couples would have avoided using contraception and continued childbearing until a son was born (Bongaarts, 2013). Now, the availability of sex detection screening (which makes it possible) coupled with declining fertility and smaller family size (which makes it desirable to sex-select to bear a son) drive the practice of gender-biased sex selection.

Where sons are preferred over daughters, it is because males and their assumed gender roles are more valued in families, communities and societies than females (Browne, 2017). There are long-standing structural drivers behind son preference. Poverty is often cited as a reason: because men stereotypically are "providers" and "protectors" of the household—earning income and defending family, community and national interests—their well-being is seen as privileged (Das Gupta and others, 2003). In contrast, women are seen as "caretakers" and are charged with homemaking, child-rearing and elder care, tasks that require little formal education and are poorly, if ever, remunerated. Girls, especially in South Asia, must therefore be "married off", requiring a costly dowry. As a result, families do not wish to be overburdened with girls and will engage in a range of practices to ensure that they have at least one son (Mitra, 2014).

Poverty, however, does not tell the entire story. Son preference can be found across socioeconomic levels, in countries where patriarchy within families persists (Miller, 2001). The persistence of son preference both reflects and entrenches the very stereotypes that are deleterious to women and girls, and governments therefore have an obligation to address it.

Treaties

Interpretations of human rights treaties identify "gender-biased sex selection" in favour of boys as a harmful practice. International human rights law, to a large extent, defers to nations to legislate on abortion (UN HRC, 2018). However, a

Mural by Maia Bobo in partnership with TackleAfrica, Burkina Faso

plethora of recognized human rights together frame son preference as manifested in gender-biased sex selection as a human rights violation.

Rights related to equality and non-discrimination:
- Women's Convention, Articles 2 and 3
- Child Rights Convention, Article 2

Rights against gender stereotyping:
- Women's Convention, Article 5(a)

The right to be secure in one's person:
- International Covenant on Civil and Political Rights, Article 9

The right to be protected from violence:
- Convention on the Elimination of All Forms of Discrimination Against Women, General Recommendations 19 and 35

The right to enjoy one's health:
- International Covenant on Economic and Cultural Rights, Article 12
- Women's Convention, Article 12

Traditional birth practices

While many traditional practices focus on the care, nurturing and support of women in the post-partum period (Dennis and others, 2007), there are also long-standing traditional birth practices that threaten the health and well-being of mothers and infants.

Some women in Turkey, for example, believe that jumping from a high point will hasten labour (Ayaz and Efe, 2008). Among some groups in western Ethiopia, it is believed that a woman's blood is cursed, so when a pregnant woman's labour begins, she is sent out of the home to the bush to give birth alone.

Some traditional practices dictate that when labour is prolonged or obstructed, violent force—such as sitting on the pregnant woman's abdomen—should be applied to force the baby out (Wall, 2012). In parts of Nigeria and Niger, "yankan gishiri", or salt cut, is practised in cases of obstructed labour. In this practice, a traditional birth attendant uses a razor blade to cut the vaginal wall, which has been shown to lead to further complications, including obstetric fistula (Yola, 2011).

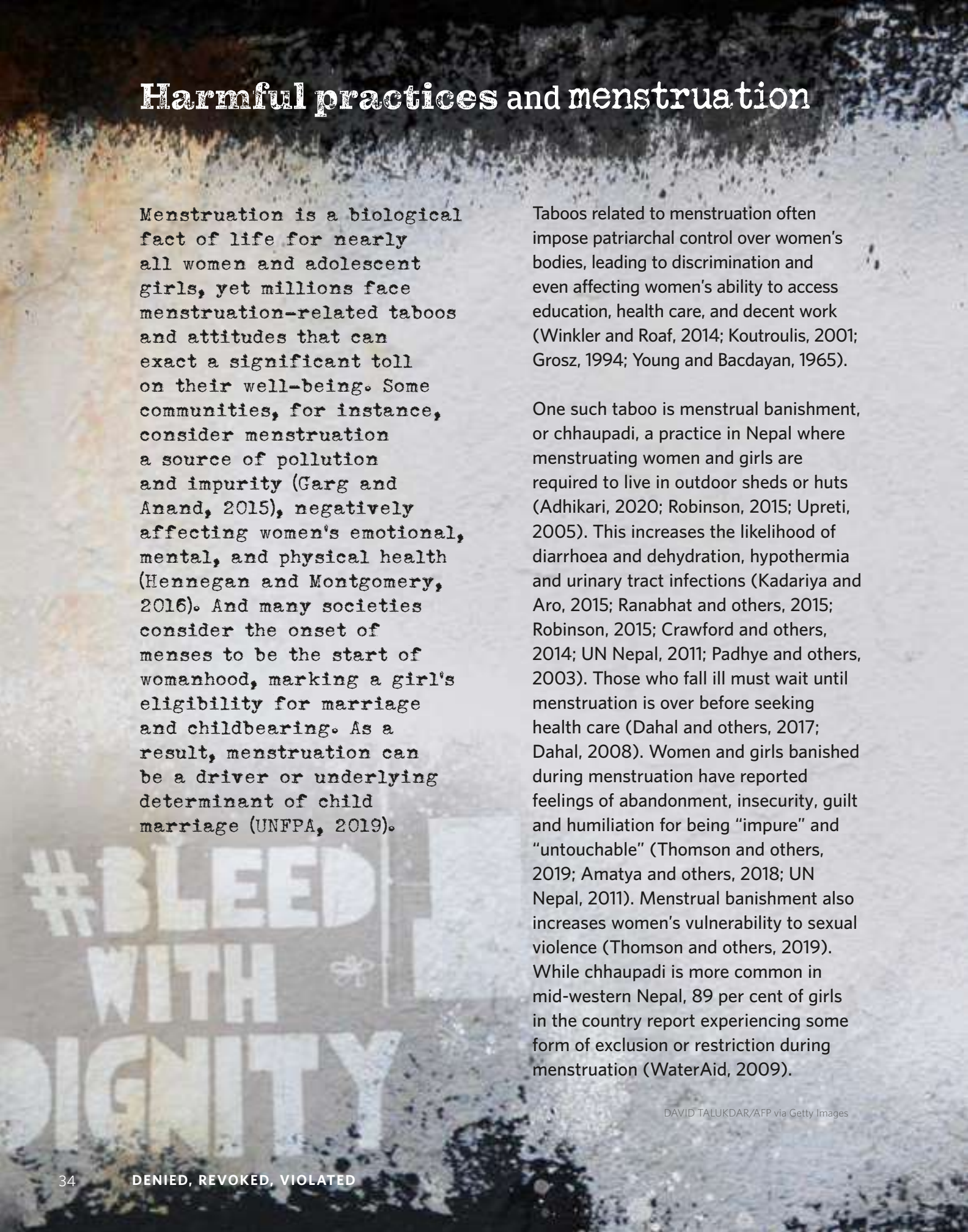
In other places, labour complications are thought to stem from a pregnant woman's transgressive behaviour, leading to delays in seeking medical assistance. Studies in West and East Africa indicate that women suffering prolonged labour are pressured to confess to infidelity, and only then will medical attention be sought (Wall, 2012).

Harmful practices and menstruation

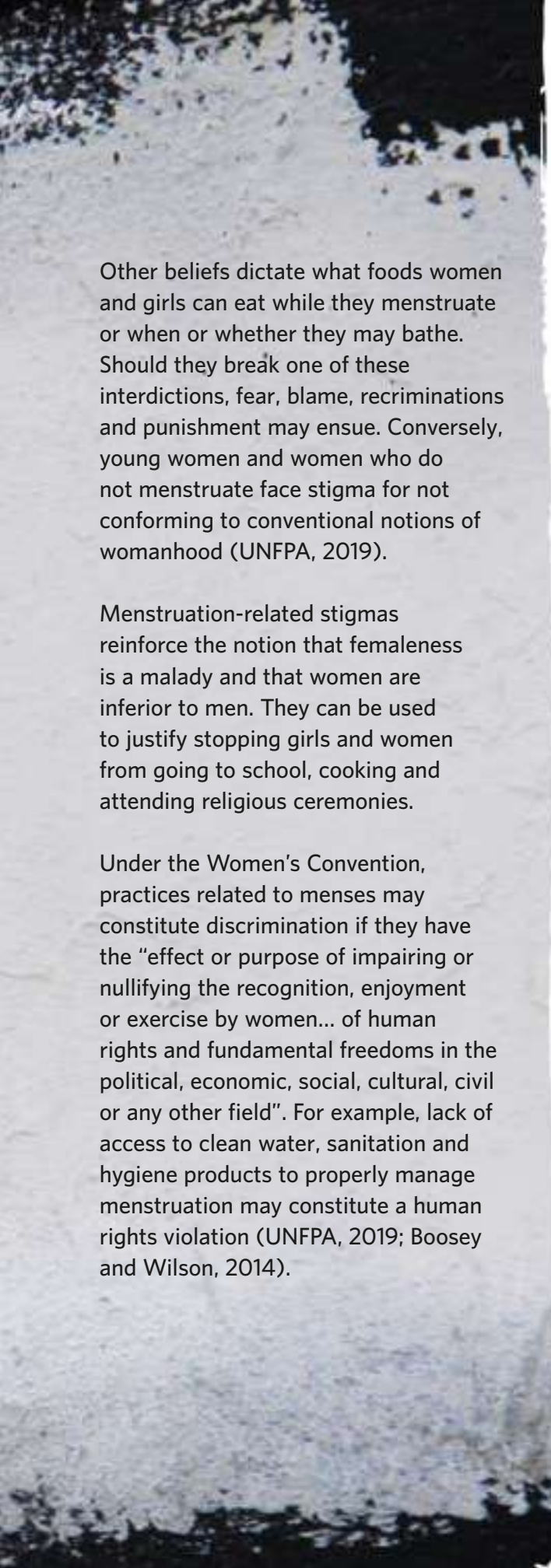
Menstruation is a biological fact of life for nearly all women and adolescent girls, yet millions face menstruation-related taboos and attitudes that can exact a significant toll on their well-being. Some communities, for instance, consider menstruation a source of pollution and impurity (Garg and Anand, 2015), negatively affecting women's emotional, mental, and physical health (Hennegan and Montgomery, 2016). And many societies consider the onset of menses to be the start of womanhood, marking a girl's eligibility for marriage and childbearing. As a result, menstruation can be a driver or underlying determinant of child marriage (UNFPA, 2019).

Taboos related to menstruation often impose patriarchal control over women's bodies, leading to discrimination and even affecting women's ability to access education, health care, and decent work (Winkler and Roaf, 2014; Koutroulis, 2001; Grosz, 1994; Young and Bacdayan, 1965).

One such taboo is menstrual banishment, or chhaupadi, a practice in Nepal where menstruating women and girls are required to live in outdoor sheds or huts (Adhikari, 2020; Robinson, 2015; Upreti, 2005). This increases the likelihood of diarrhoea and dehydration, hypothermia and urinary tract infections (Kadariya and Aro, 2015; Ranabhat and others, 2015; Robinson, 2015; Crawford and others, 2014; UN Nepal, 2011; Padhye and others, 2003). Those who fall ill must wait until menstruation is over before seeking health care (Dahal and others, 2017; Dahal, 2008). Women and girls banished during menstruation have reported feelings of abandonment, insecurity, guilt and humiliation for being "impure" and "untouchable" (Thomson and others, 2019; Amatya and others, 2018; UN Nepal, 2011). Menstrual banishment also increases women's vulnerability to sexual violence (Thomson and others, 2019). While chhaupadi is more common in mid-western Nepal, 89 per cent of girls in the country report experiencing some form of exclusion or restriction during menstruation (WaterAid, 2009).



DAVID TALUKDAR/AFP via Getty Images



Other beliefs dictate what foods women and girls can eat while they menstruate or when or whether they may bathe. Should they break one of these interdictions, fear, blame, recriminations and punishment may ensue. Conversely, young women and women who do not menstruate face stigma for not conforming to conventional notions of womanhood (UNFPA, 2019).

Menstruation-related stigmas reinforce the notion that femaleness is a malady and that women are inferior to men. They can be used to justify stopping girls and women from going to school, cooking and attending religious ceremonies.

Under the Women's Convention, practices related to menses may constitute discrimination if they have the "effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women... of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field". For example, lack of access to clean water, sanitation and hygiene products to properly manage menstruation may constitute a human rights violation (UNFPA, 2019; Boosey and Wilson, 2014).

Gender stereotypes, equality and non-discrimination

Decisions to carry to term male but not female fetuses is a reflection of gender-discriminatory views that women and girls are worth less than men and boys. The rejection of female fetuses because a daughter is not wanted (but a son is) sends a message of girls' and women's inferiority, offending human rights through their ultimate devaluing. As such, the practice of gender-biased sex selection is both a cause and a consequence of the "persistence of deep-rooted stereotypes on the roles and responsibilities of women" and violates the human right to be treated equally, without regard to gender (UN CEDAW, 2014). Ultimately, one of the many manifestations of son preference is a sex ratio at birth that skews to male because of gender-biased sex selection (Pande and Malhotra, 2006).

The Human Rights Committee, which monitors compliance with the International Covenant on Civil and Political Rights, has reminded States Parties that gender-biased sex selection is a reflection of the subordination of women and that they therefore have an obligation to address the root causes (UN HRC, 2000).

Violence and health

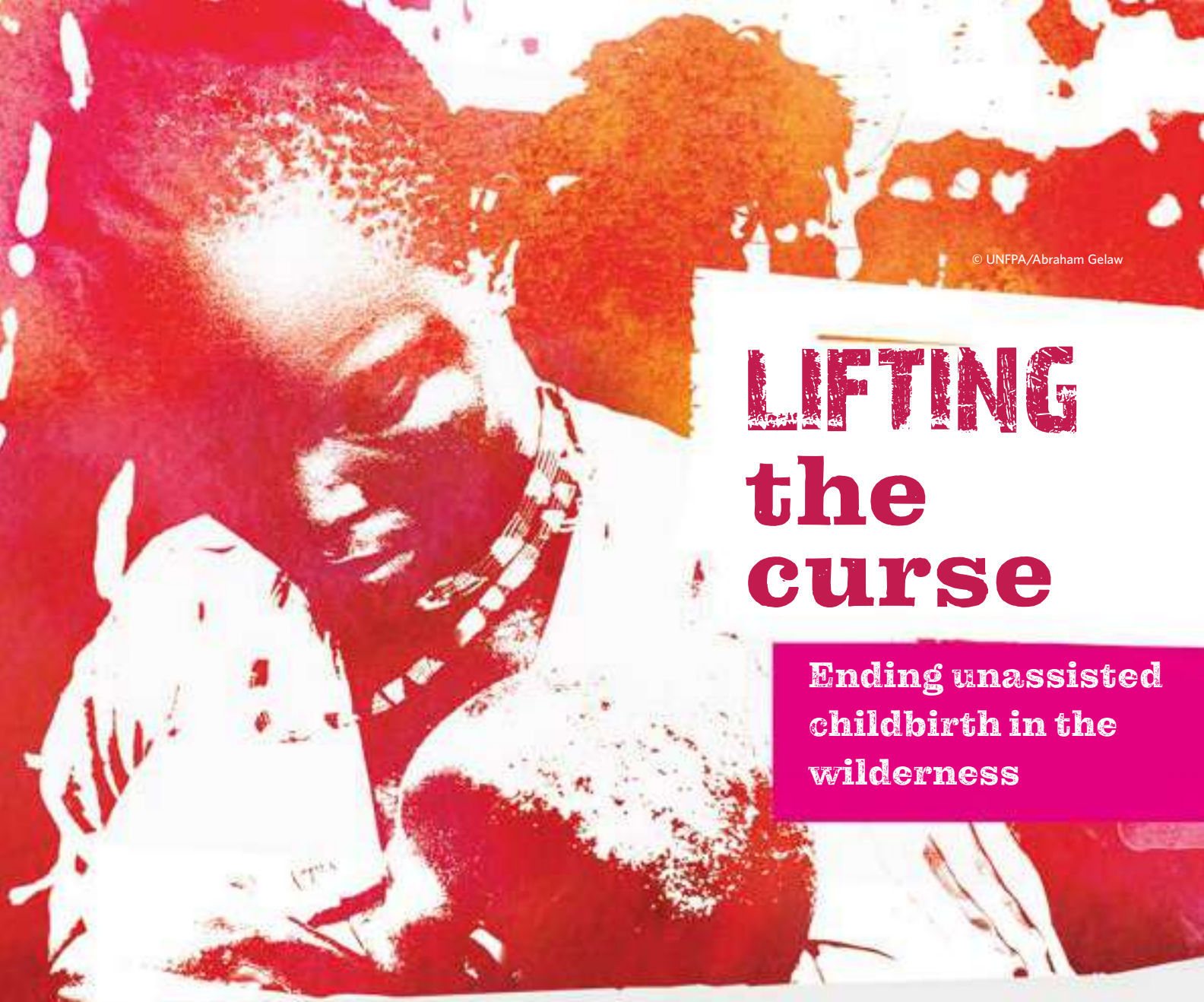
In societies where there are many more men than women of marriageable age, women are more vulnerable to sexual and gender-based violence (Diamond-Smith and Rudolph, 2018). Trafficking of women for domestic

and sex work, as well as marriage, is also a documented concern (WHO, 2011). And, while all pregnant women are at a higher risk of intimate partner and family violence than non-pregnant women, those who fail to give birth to sons are at increased risk (Muchomba, 2019). Women who are unable to bear any children or who are blamed for a couple's infertility are also at heightened risk of domestic and familial violence (Stellar and others, 2016).

Violence leads to physical injury and mental distress and therefore has obvious consequences for the enjoyment of health. Women's health is further compromised by son preference as they may "go through repeated pregnancies until they give birth to sons. In the process, women's health deteriorates as many do not have access to adequate diet, nutrition, and pre- or postnatal care" (Mitra, 2014). They face emotional and mental health stressors surrounding their pregnancies, having internalized the notion that their self-worth and social value rests not only on delivering a child but specifically a son (Mitra, 2014). The underlying reasons may have to do with stereotypical gender roles that males and females are expected to undertake, replete with financial benefits and burdens, such as dowry. Assaults to an individual's sense of self-worth can translate into mental and physical ill health (Krieger, 2000).

What governments are obligated to do about it

Like child marriage and FGM, the recognition of gender-biased sex selection as a form of gender-based discrimination requires States "to modify [such] social and cultural patterns of conduct" according to Article 5(a) of



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LIFTING the curse

Ending unassisted childbirth in the wilderness

In Ethiopia's Gumuz community, women's blood has long been considered cursed, and during menstruation and childbirth, some women are required to leave their homes.

Abebech Kabla had to give birth alone in the woods—three times. Each time, she thought she might die. The first time, she was only 13 years old, a year into her marriage.

"Even after giving birth, I didn't go back to my house for seven days until I became clean from blood," she describes.

But by the time she was pregnant with her fourth child, practices in the community had begun to change.

An organization called the Mujejeguwa Loka (meaning "dawn light" in the Gumuz language)

Women's Development Association was working to change attitudes about women's and girls' rights. Volunteers with the organization—all members of the community—were raising awareness about harmful practices that were injuring and killing women, not only unassisted childbirth in the bush, but also child marriage and female genital mutilation.

Abebech insisted on giving birth indoors, where someone could assist if complications arose. "At first it was very challenging for the men to accept this, and the family was pointing fingers at me, that I would be held responsible if any curse befell the house after I gave birth at home."

But nothing bad happened during or after the childbirth, and Abebech felt vindicated, she says.

Today, Mujejeguwa Loka has been active in the area for more than 20 years.

Boge Porre is one of the organization's volunteers. She says discouraging unassisted childbirth in the bush has been a colossal task, with women facing threats and intimidation at every turn. Even now, the practice still takes place, though it is less common.

Women forced to give birth alone face serious risks, including death. These women often go without antenatal and post-partum care, even if they experience serious complications. "When we come across cases of uterine prolapse and fistula we advise the women that Mujejeguwa Loka will help them to get treatment for their condition," Boge explains.

She and her fellow volunteers say they have seen great progress over the years. They have added sexual and gender-based violence to the list of problems they are trying to eradicate from the community. They report cases of harmful practices to Mujejeguwa Loka, which alerts the authorities. This has angered some community leaders and elders, who prefer to resolve issues through traditional means. Despite the opposition, Boge is undeterred.

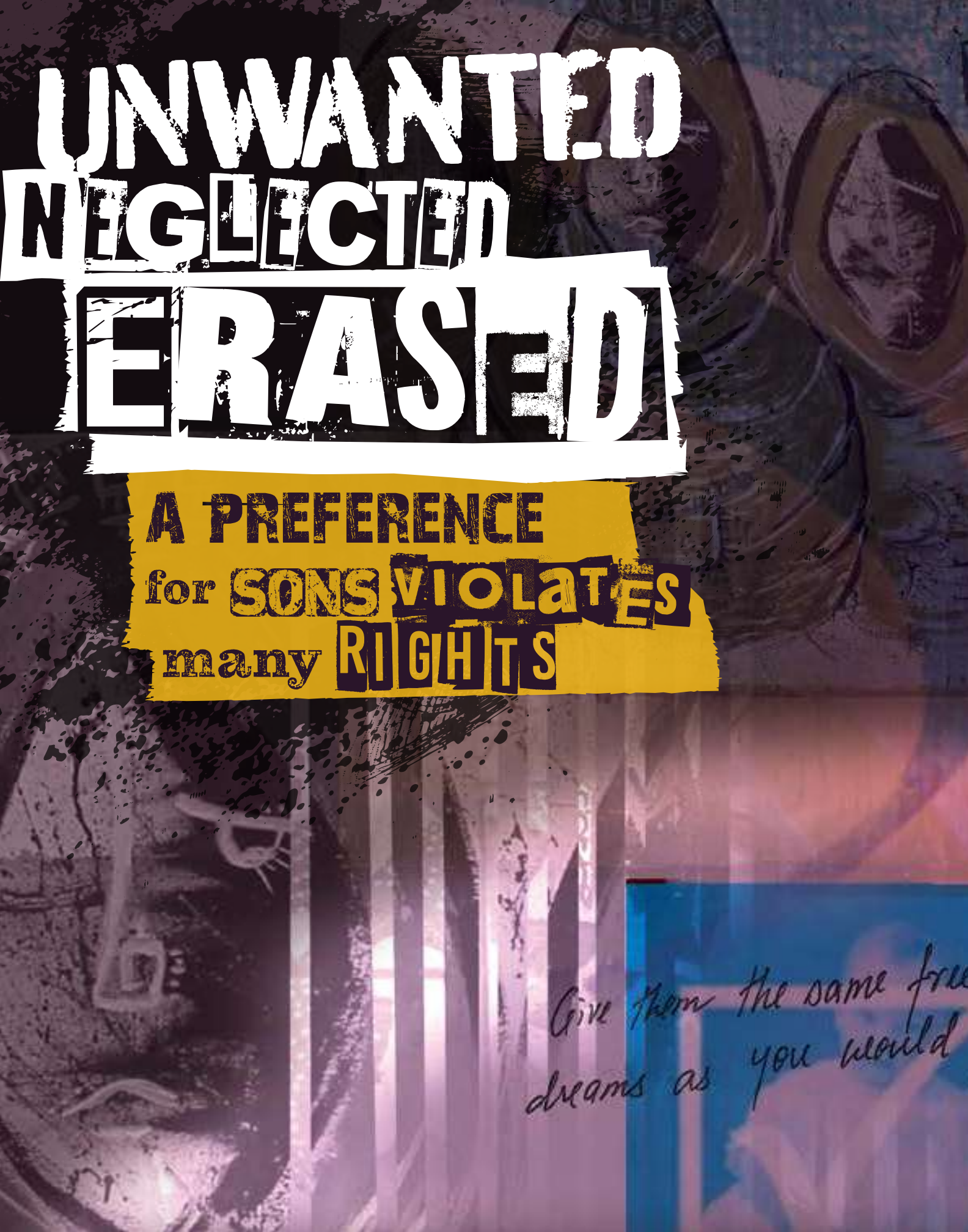
> "At first it was very challenging for the men to accept this, and the family was pointing fingers at me, that **I would be held responsible** if any curse befell the house after I gave birth at home."

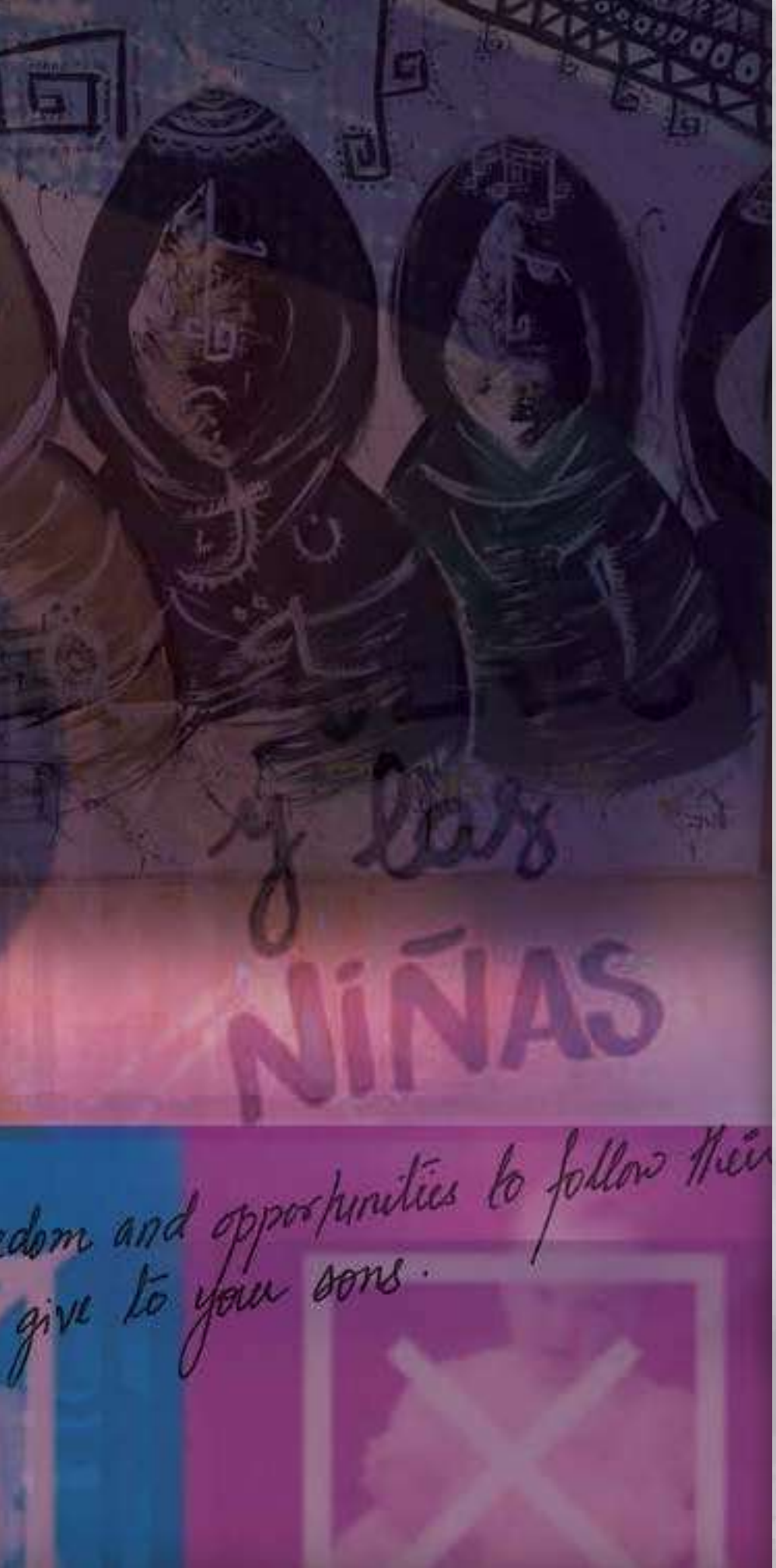
the Women's Convention. In 1994, at the International Conference on Population and Development, 179 governments committed to "eliminate all forms of discrimination against the girl child and the root causes of son preference, which result in harmful and unethical practices regarding female infanticide and prenatal sex selection". More recently, governments endorsing Sustainable Development Goal 5, for gender equality, agreed to prohibit harmful practices, including gender-biased sex selection.

Human rights and the end of harmful practices

The formal system of international human rights promotion and protection establishes clear guidance on harmful practices: they must be stopped. Even though practices such as FGM, child marriage and gender-biased sex selection constitute human rights violations, they persist. States may pass laws that help transform underlying norms to which harmful practices are tethered, but still girls' genitalia are mutilated and girls are forced into marriage. They are made to feel inferior to boys and subordinate to men in ways that force them to conform to society's ideals of what it means to be female.

In legislating against harmful practices, especially attaching harsh punitive sanctions to them, States should nonetheless take care to see that laws and policies do no harm to the girls and women they are meant to protect. This requires an analysis of the social determinants of each harmful practice to help formulate laws and policies that are effective and do not infringe on other rights. Otherwise States risk non-enforcement, community rejection and clandestine practice. Even when harmful practices are investigated, prosecuted and punished, this has little effect on dislodging long-standing and entrenched customs and beliefs. Therefore, together with legislation and policy, public education and awareness-raising efforts by governments and non-governmental actors are key (Das Gupta, 2019). Indeed, they may be more crucial than laws in terms of fulfilling a State's human rights obligations.


UNWANTED
NEGLECTED
ERASED
A PREFERENCE
for SONS VIOLATES
many RIGHTS
Give them the same free
dreams as you would



When BOYS are valued more highly than girls, pressure to have a son is intense. The preference for sons over daughters may be so pronounced in some societies that couples will go to great lengths to avoid giving birth to a girl or will fail to care for the health and well-being of a daughter they already have in favour of their son.

Son preference is anything but a benign tradition. Instead, it is a symptom of entrenched gender inequality, which harms whole societies.

Son preference and sex selection

Son preference is a product of gender-biased systems that assign and reinforce higher social status to men and boys and that favour male over female children (Croll, 2000; Miller, 1981).

In some parts of the world, the birth of a boy is a cause for celebration. The birth of a girl, however, can be a reason for disappointment. She may be seen as a burden, a liability, an impediment to a family's future. She may be forgotten, ignored, underfed. She may die from neglect. She may die from neglect or more intentional acts, all amounting to *postnatal sex selection.*

Son preference may also be expressed through *gender-biased sex selection*: the termination of a pregnancy when the fetus is determined to be female, or pre-implantation sex determination and selection, or "sperm-sorting" for in-vitro fertilization. From a human rights perspective, gender-biased sex selection is a harmful practice because it translates a preference for boys over girls into a deliberate prevention of female births. Unambiguously linked to discriminatory norms and behaviours, it is a malignant outcome of gender inequality.

Son preference and gender-biased sex selection are linked but not synonymous: it is possible for there to be son preference without gender-biased sex selection. In some low-income countries of Asia and sub-Saharan Africa, for example, son preference is widespread, but postnatal and gender-biased sex selection are uncommon.

Preferring to have a son rather than a daughter is not in itself a human rights violation.

MOTHER, REBEL AND ROLE MODEL

One woman stands firm against son preference

"My stomach was huge, so I knew that I was carrying more than one child. What I didn't know was that they were going to be all girls," 58-year-old Jasbeer Kaur says, smiling at her 23-year-old triplets, Mandeep, Sandeep and Pardeep Kaur, as they huddle together in their tiny kitchen, preparing lunch.

"People here in my village often tell me, poor thing... you should have had at least one son instead of three daughters. And I tell them, spare me this rubbish! I am a woman and I am proud of having raised these girls who are now grown women," Kaur says. "Then these people look at my daughters and when they see how bold they are they say, they are just like their mother!"

The three siblings laugh when their mother narrates this story. Over the years they've learned to see the lighter side of things, even though they're acutely aware that their very existence is, in so many ways, an anomaly.

Just a few months into her marriage, young Kaur realized that the man her parents had married her off to wasn't someone she wanted to spend the rest of her life with. Her husband was an alcoholic who was rarely kind. But things were about to get worse.

"I was pregnant and during one of the ultrasounds, the doctor told me I was having not one, but three children... three daughters. Now it is banned but, in those days, they would tell you the sex of the child. The doctor offered to conduct an abortion, because she said it would be difficult for me to raise three daughters. She even explained that the procedure would be a straightforward one, similar to a delivery. For a few moments, I was scared, but God gave me strength to refuse and I said no," Kaur recalls. "When I told my mother, she said, if I can raise daughters, so can you."

But her husband and in-laws weren't so supportive.

"No daughter had been born in my husband's family in the last three generations. They told me, we won't allow three daughters to be born in the house at the same time. They gave me an ultimatum: Get an abortion or leave," Kaur says.

She chose to leave. And never looked back.

It wasn't easy raising and educating three children, but grit and determination were on her side. She worked as an auxiliary nurse midwife in India's Rajasthan, earning a meagre salary that kept them afloat.

> "When I told my mother, she said, **IF I CAN RAISE DAUGHTERS, so CAN YOU.**"

The triplets have done their mother proud.

Today, Sandeep is a make-up artist in Amritsar, with dreams of making it to Bollywood one day. Pardeep, after pursuing a degree in hotel management, is now interning at a five-star hotel. Mandeep is following in her mother's footsteps; she is close to earning a degree in nursing.

"As kids, we would often wonder why our father never came for school functions like other fathers," says Sandeep, "or why we would often see Mummy cry at home."

"It's only when we were much older that our aunt and grandmother told us the story of how we came to be born," adds Pardeep. "That's when it all began to make sense."

"We are so very proud of what Mummy has been through," says Mandeep. "But it's not something we can talk about with our friends, because we know their immediate response will be one of pity, which is something we don't want from anyone."

But pity is the last thing that comes to mind when neighbours speak about the Kaur family. In a society still largely obsessed with sons, Kaur is a living example all the local women cite with pride.

"Here, people still think that you need a son, because without a son how can you carry forward the family's name. You see, as a

mother, you haven't done your bit till you've given birth to a son," explains a neighbour with two daughters. "But I think daughters are more important because they take more care of their parents than sons do. And if Jasbeer Kaur can raise three daughters on her own, why can't we raise daughters when we enjoy our families' support?"

A deeply entrenched preference for male children continues, and some families still seek to abort female fetuses, even though gender-biased sex selection has been banned, or neglect the nutrition and health of daughters in favour of sons. After birth, girls face higher mortality rates than boys, an indication that they are facing discrimination in care.

Between 2013 and 2017, about 460,000 girls in India were "missing" at birth each year. According to one analysis, gender-biased sex selection accounts for about two thirds of the total missing girls, and post-birth female mortality accounts for about one third (Table 3.5).

A single mother raising female triplets is a rarity anywhere, and particularly in rural Rajasthan. Kaur's daughters know the hardships and stigmas their mother overcame, and they are determined to make her proud. They want to leave behind a legacy that honours her hard work.

"Today, people know us as Jasbeer Kaur's daughters," says Sandeep. "We want to make something of our lives... We want people to say, this is Jasbeer Kaur, she is Sandeep, Mandeep and Pardeep's mother."

Son preference, however, is enmeshed in a web of social relations that reflect, produce and reproduce gender stereotypes. It is the perpetuation of stereotypes, particularly those that mark male superior to female and lead to the subordination of women to men and girls to boys, that constitutes human rights violations.

Measuring son preference

Because son preference is the product of many forms of gender discrimination, measuring its scope and severity—and formulating policies and interventions to address it—can be difficult.

But some insights are possible from analysis of demographic and household surveys. Parents' views about the gender composition of their ideal families or their desire for additional births, for example, may reveal an overall desire for sons, or a desire for more children in families with daughters only (Fuse, 2010). Surveys may also show that parents prefer a family with both a son and a daughter, but what they really may prefer is any combination, provided they have at least one son. However, survey responses may reflect only views, not actual behaviour.

Unlike son preference in general, the manifestation of it in gender-biased sex selection may be more directly measured through a country's data on "sex ratio at birth" (Guilmoto, 2015). The "natural" or normal, sex ratio at birth in most parts of the world is between 105 and 106 male births for every 100 female births (Chahnazarian, 1988). Any deviation from this natural sex ratio at birth therefore reflects some degree of gender-biased sex selection (Chao and others, 2019; Tafuro and Guilmoto, 2019).

An accurate analysis of sex ratios depends on complete and reliable birth registration statistics and on sufficiently large sample sizes (Shi and Kennedy, 2016; Goodkind, 2011). To enable international comparisons of sex ratios, especially in countries with few annual births, the United Nations estimates countries' sex ratios covering five-year periods. Nationally collected birth statistics, often derived from censuses, may, however, offer more current insights into the share of males and females in a population (Table 3.1).

An analysis of the "sex ratio of children" can offer insights into both the extent of gender-biased sex selection and the extent of postnatal sex selection because it also captures some of the effect of deliberate neglect of girls, resulting in

TABLE 3.1 Selected countries and territories which have or had skewed sex ratios

Recent estimates of sex ratio at birth†

		Projections for 2017* (model-based estimates)	**Most recent measurements**** (other sources)	
Region	**Country or territory**	Sex ratio at birth ***	Sex ratio at birth ***	Period and source
Asia	China	114.3	111.9	2017[a]
	Hong Kong, SAR of China	107.8	106.6	2018[b]
	Taiwan, Province of China	107.6	107.0	2018[b]
	India	109.8	111.6	2015–2017[c]
	Nepal	107.3	110.6	2012–2016[d]
	Republic of Korea	105.6	105.4	2018[b]
	Singapore	106.5	106.1	2018[b]
	Viet Nam	112.2	111.5	2018[e]
South Caucasus	Armenia	111.7	111.1	2018[b]
	Azerbaijan	113.4	114.6	2018[b]
	Georgia	106.5	107.9	2018[b]
South-East Europe	Albania	108.3	108.0	2018[b]
	Montenegro	107.2	106.7	2016–2018[b]
	Kosovo[f]	No available estimate	109.0	2018[b]
North Africa	Tunisia	105.4	107.0	2017[b]

† Selected countries have sex ratio imbalances at today or have had them in the past 30 years, according to statistics and field evidence. Figures have been calculated over available series of annual births. Estimates of sex ratios at birth may be affected by measurement errors due to lack of well-functioning birth registration or selective underreporting as well as by yearly fluctuations.

* Bayesian forecasts for 2017 based on 1950–2015 series (Chao and others, 2019).

** Based on raw data from birth registration or surveys.

*** Sex ratio at birth expressed in male births per 100 female births.

a National bureau of statistics

b Birth registration

c Sample registration system

d Demographic and Health Survey sample survey

e 2019 census

f Data for Kosovo are referenced in accordance with United Nations Security Council Resolution 1244 (1999)

their deaths before adulthood (Cai and Lavely, 2003). The advantage of this measure is that it is based on data about age and sex distributions systematically collected through censuses.

Some research looks at the death rates of girls—finding the highest in India—though analysis of the scope and intensity of postnatal sex selection is made difficult by the lack of reliable data by sex and age in developing countries. Alkema and others (2014) used an array of sources to develop estimates of "excess female mortality", even for countries that lacked regular censuses and reliable birth registration figures (Table 3.2). According to their analysis, India has the highest rate of excess female deaths, 13.5 per 1,000 female births, which suggests that an estimated one in nine deaths

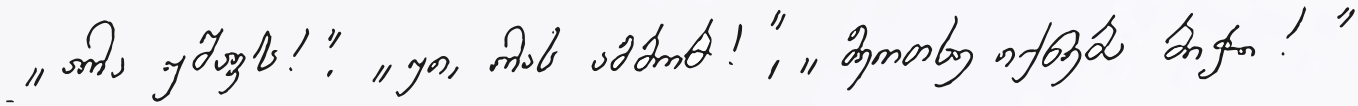
TABLE 3.2

Deaths of some girls are attributable to neglect and other forms of postnatal sex selection

Estimates of excess female mortality below age 5, and its share of overall mortality rates among girls below age 5 in 2012

Country or territory	Excess female mortality rate	As a percentage of the overall female under-5 mortality
Afghanistan	5.2	2.7%
Bahrain	1.1	5.9%
Bangladesh	2.1	2.6%
China	1.0	3.3%
Egypt	2.4	5.6%
India	13.5	11.7%
Iran	1.8	5.2%
Jordan	1.9	5.0%
Nepal	2.9	3.5%
Pakistan	4.7	2.7%

Mortality rates are per 1,000 births. Excess female mortality rates are calculated as the difference between observed and expected mortality rates for females below age 5. Proportion of overall mortality is calculated using observed mortality rates for females below age 5. Calculations are based on Bayesian estimates of the sex ratio of mortality rates below age 5. (Alkema and others, 2014)



"Oh, that's a pity!" "Don't worry!" "The fourth child will be a boy!"

Tekla, 34 years old, Georgia

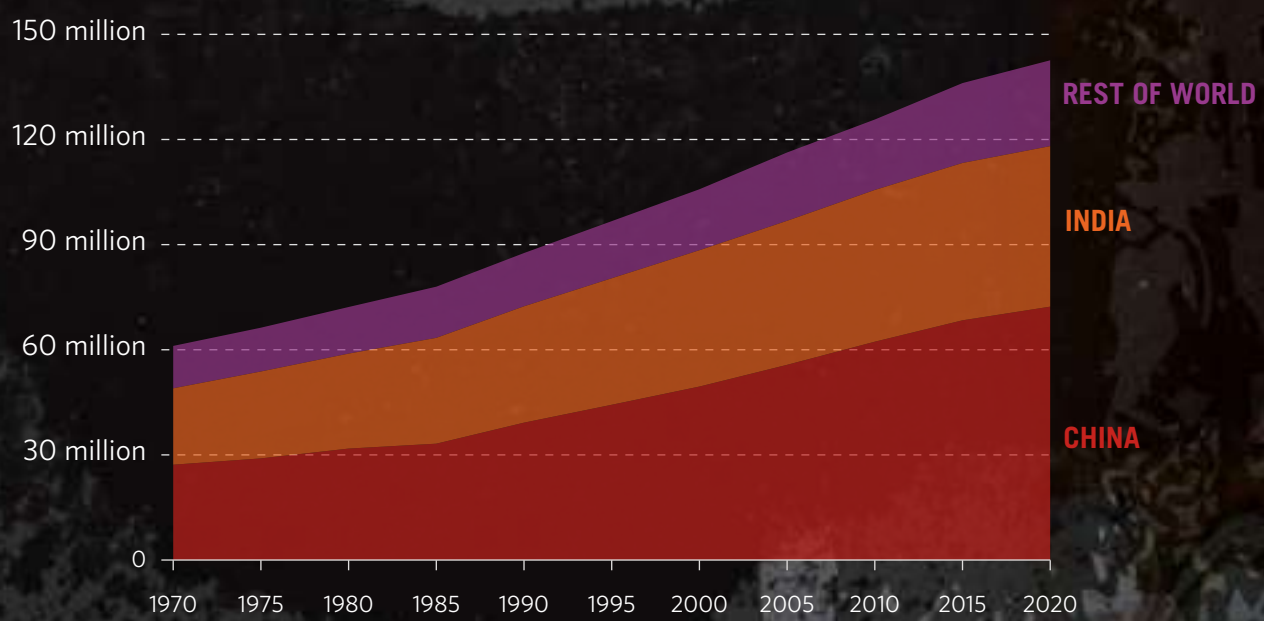
of females below the age of 5 may be attributed to postnatal sex selection. This same analysis shows that in Afghanistan, Bangladesh and Pakistan excess female mortality represents nearly 3 per cent of deaths of girls below the age of 5. Bahrain, Egypt, Iran and Jordan also experience excess female mortality, but in these countries, according to the researchers, gender-biased sex selection does not occur.

Excess female deaths around the world rose between the 1970s and 1990, when they peaked at about 2 million annually (Table 3.3 and Figure 3.1), according to research based on United Nations population distribution figures. The decline of excess female deaths that followed may be partly attributed to increased access to ultrasound imaging and other technologies, which in turn led to an increase in gender-biased sex selection (Bongaarts and Guilmoto, 2015).

This same research also indicates that the number of females who were missing because of gender-biased sex selection as of 2015 was larger than those who were missing because of postnatal sex selection (Table 3.3).

FIGURE 3.1 **Number of "missing females" in the world**

Estimates of missing females, in selected populations, in millions, as of 2020†*



* "Missing females" are those whose numbers are reflected in sex ratio imbalances at birth as a result of gender-biased (prenatal) sex selection, combined with excess female mortality stemming from postnatal sex selection.

† Annual numbers of excess female deaths and missing female births are for the period 2015–2020, estimated and described in Bongaarts and Guilmoto (2015). Excess female deaths and missing female births refer to the preceding five-year period.

Levels and trends

Data from national statistical offices and indirect estimates show that 15 countries or territories have had noteworthy sex-ratio imbalances at birth and are diverse in terms of their social and religious compositions, political systems and economies (Table 3.1). The observed values range from about 115 male births per 100 female births to levels that are below 110, or even close to the natural sex ratio at birth, 105 to 106 male births per 100 female births. Three of the countries—the Republic of Korea, Singapore

An accurate analysis of sex ratios depends on complete and **RELIABLE BIRTH REGISTRATION STATISTICS** and on sufficiently large sample sizes.

TABLE 3.3

The number of "missing women" has more than doubled over the past 50 years

Estimates of global missing females, excess female deaths and missing female births, in millions, 1970–2020

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020
Missing females*	61.0	66.4	72.2	79.3	87.6	96.7	105.9	116.4	125.6	136.2	142.6
Excess female deaths**		1.79	1.86	1.90	1.97	1.93	1.71	1.78	1.66	1.65	1.71
Missing female births***		0.00	0.00	0.37	0.76	1.23	1.36	1.55	1.71	1.69	1.50

*"Missing females" are females missing from the population at given dates due to the cumulative effect of postnatal and prenatal sex selection in the past.
**"Excess female deaths" are female deaths attributable to postnatal sex section.
***"Missing female births" are female births prevented by gender-biased (prenatal) sex selection.
Excess female deaths and missing female births refer to the preceding five-year period. Estimates from Bongaarts and Guilmoto (2015).

Artwork courtesy of Sandra AlMoussa, Syria Y-Peer

and Tunisia—once had sex ratio imbalances but today have sex ratios at birth that are close to the natural level.

Tables 3.4 and 3.5 show that two countries—China and India—together account for about 90 per cent to 95 per cent of the estimated 1.2 million to 1.5 million missing female births annually worldwide due to gender-biased (prenatal) sex selection (Chao and others, 2019; Bongaarts and Guilmoto, 2015). These two countries also account for the largest total number of births each year.

Skewed sex ratios at birth influenced by gender-biased sex selection emerged in the 1980s in China, India and the Republic of Korea, in the 1990s in Eastern European countries, and after 2000 in Nepal and Viet Nam (UNFPA, 2017, 2012; Frost and others, 2013; Guilmoto and

TABLE 3.4 **Missing female births total nearly 1.2 million annually**

Estimates of missing female births due to gender (prenatal) sex selection in selected countries and territories, averaged over a five-year period†

	Country or territory	Missing female births*
Asia	China	666,300
	Hong Kong, SAR of China	100
	Taiwan, Province of China	1,200
	India	461,500
	Nepal	No available nationally representative data
	Republic of Korea	0
	Singapore	No available nationally representative data
	Viet Nam	40,800
South Caucasus	Armenia	1,100
	Azerbaijan	6,200
	Georgia	100
South-East Europe	Albania	500
	Montenegro	100
	Kosovo[1]	No available nationally representative data
North Africa	Tunisia	1,400
GLOBAL		**1,179,000**

† Selected countries and territories are those with current or past sex ratio imbalances at birth. Nationally representative data are not available for three countries or territories. Figures have been estimated based on median Bayesian estimates of trends and of biological sex ratio at birth. The annual average was computed using 2013–2017 estimates. Estimates may vary according to methodology.

* "Missing female births" are female births prevented by gender-biased (prenatal) sex selection.

[1] Kosovo is referenced in accordance with United Nations Security Council Resolution 1244 (1999).

(Chao and others, 2019).

Duthé, 2013; GSO, 2011; Bhat and Zavier, 2007; Das Gupta and others, 2003).

The proportion of male births among some diaspora communities in North America and Europe is higher than expected (Almond and others, 2009; Dubuc and Coleman, 2007). Hong Kong SAR of China, Taiwan Province of China and Singapore also recorded a rise in their proportion of male births. This suggests that gender-biased attitudes and practices can persist even in different political, social and economic environments.

Over the past two decades, the skewed sex ratios in most affected countries have begun to return to normal. In the Republic of Korea and Singapore, ratios have nearly reached natural levels. In Viet Nam, the last country to have experienced a sizable shift in its sex ratio

TABLE 3.5 **Two countries account for the majority of the world's missing females**

Estimates of missing females, annual excess female deaths and missing female births in 2020 (figures in millions)

	WORLD TOTAL	China	India	Other countries
Missing females*	142.6	72.3	45.8	24.5
Excess female deaths**	1.71	0.62	0.36	0.72
Missing female births***	1.50	0.73	0.59	0.17

* "Missing females" are those whose numbers are reflected in sex ratio imbalances at birth as a result of gender-biased (prenatal) sex selection, combined with excess female mortality stemming from postnatal sex selection.

** "Excess female deaths" are female deaths attributable to postnatal sex selection.

*** "Missing female births" are female births prevented by gender-biased (prenatal) sex selection.

Annual numbers of excess female deaths and missing female births are for the period 2015–2020, estimated and described in Bongaarts and Guilmoto (2015).

Artwork courtesy of Fatma Mahmoud Salama Rasian

at birth, the trend has finally peaked and has begun to level off, signalling the possible start of a decline (Becquet and Guilmoto, 2018). However, in India, rises in some parts of the country are offsetting decreases in others, and in some states there are an estimated 120 male births per 100 female births (Kulkarni, 2019).

National averages may mask skewed sex ratios at birth in specific regions (Kumar and Sathyanarayana, 2012; GSO, 2011). Variations within countries can be dramatic, differing from north to south or urban to rural, or by wealth, education and size of the family. In China, for example, higher ratios are concentrated in the southern part of the country. In India, meanwhile, ratios tend to be higher in urban areas (Figure 3.2), but in Azerbaijan, China and Viet Nam, they are lower.

Gender-biased sex selection tends initially to be higher among wealthier segments of society but over time reaches lower-income families as technologies that facilitate sex selection become more accessible and affordable.

The number of births and sex of each child can also be factors. In general, couples do not engage in gender-biased sex selection for their first child. However, they may subsequently opt for sex-selective abortions if their first child was a girl. In Armenia, for example, the sex ratio is normal for couples' first two births; however, parents with two girls may then choose sex-selective abortions to ensure their third child is a boy. In 2001, measured census data revealed that the sex ratio at birth among women who already had two girls increased to 223 (UNFPA, 2013). Similar patterns have been seen in Albania, Georgia, Kosovo and some parts of India, especially among more educated and wealthier households (Kulkarni, 2019).

In China in 1990, for couples that already had one child, the sex ratio at birth for a second child rose to about 121 male births for every 100 female births. Ten years later, it had risen to about 152 (NWCCW and others, 2018).

What drives sex selection?

Son preference and the gender inequality that underlies it are the main drivers of gender-biased and postnatal sex selection (Murphy and others, 2011; UNFPA, 2011; Kaser 2008; Miller, 2001; Croll, 2000). However, there are two other preconditions of gender-biased sex selection: technology and the trend towards smaller family size (Guilmoto, 2009).

Technology

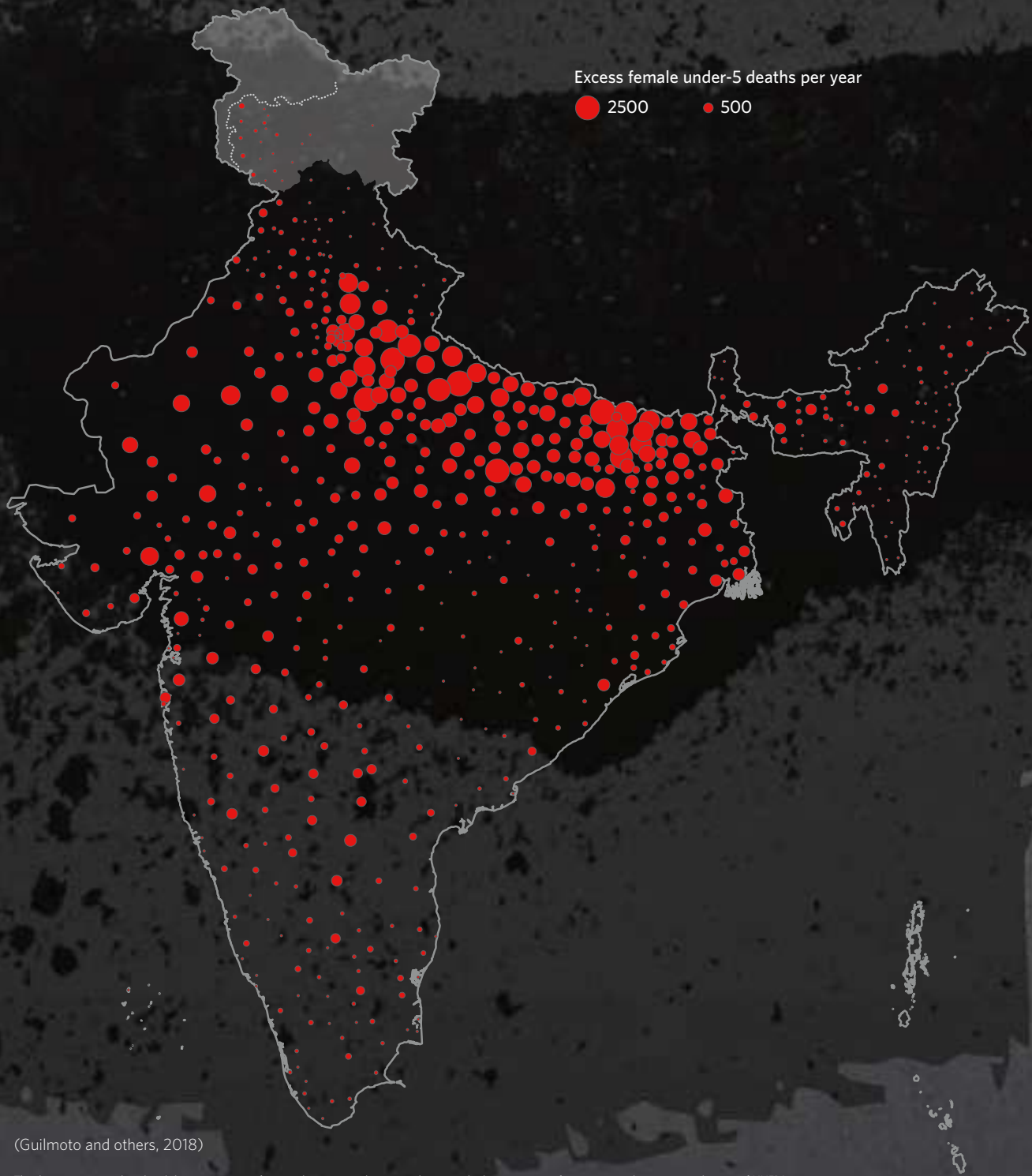
In the past, couples that wanted a son resorted to methods such as consuming foods believed to increase the chances of giving birth to a boy. Some couples with a son preference also practised postnatal sex selection when they neglected the health and nutrition of daughters or, in some extreme cases, resorted to female infanticide (D'Souza and Chen, 1980). Also in the past, a couple that was unable to have a son might have resorted to measures such as adopting a boy from a relative or abducting someone else's child.

Since the 1960s, modern contraceptives, such as the pill, have played a role in some couples' expression of son preference. Once a couple has had a son, they use contraception to prevent the birth of any further children (irrespective of which sex those children may be). This is

FIGURE 3.2

Deaths of girls in India attributable to neglect and other forms of postnatal sex selection

Annual number of excess female deaths below age 5, circa 2003



(Guilmoto and others, 2018)

The designations employed and the presentation of material in maps in this report do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries. A dotted line approximately represents the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not been agreed upon by the parties.

evidenced in a large number of families with a boy as the last child (Bongaarts, 2013).

Since the 1970s, technology, particularly ultrasound imaging, has made it possible to know the sex of fetuses (UNFPA, 2012), and couples with a strong preference would rely on this information to make decisions about whether to abort a pregnancy or to carry it to full term. Gender-biased sex selection, however, also depends on access to abortion after the first trimester, the point at which ultrasound technology can detect the sex of a fetus.

The trend towards smaller families

Globally, women are having fewer children. Fifty years ago, a woman had an average of about five children. Today, she has fewer than three. Where family size is smaller, the chance of couples not having sons is greater. About one in four parents with two girls, for example, may resort to gender-biased sex selection to avoid the birth of a third girl (Jayachandran, 2014; Guilmoto, 2009). This phenomenon, known as a "fertility squeeze", is more common in countries with family planning policies aimed at a maximum family size of one or two children because parents may not be free to have as many children as necessary to have a family with at least one boy (Ebenstein, 2010). In China, for example, the national family planning policy before 2015 allowed parents in rural areas to have a second child only if the first child was a girl. Some of these couples, wishing to have a son instead of a second daughter, sought sex-selective abortions.

Together, the forces of son preference, technology and trends towards smaller family size have driven gender-biased sex selection.

Youngsook Cho sits in the book-strewn top floor of a building dedicated to women's rights. The six-storey building in Seoul, the capital of the Republic of Korea, houses a variety of women's groups, explains Cho, one of the leaders of the feminist coalition Korean Women's Associations United (KWAU). "Each group has a different issue and a different agenda," she says, "but when we need to change laws, policies and programmes, we unite together."

Unsung HEROES

How one generation of feminists overthrew the deep-rooted preference for sons

©ImaZinS

She knows from experience the power of collective action.

She and other activists spent decades working, successfully, to transform the country's deep-seated cultural preference for sons. In fact, the Republic of Korea is one of the only countries in the world to have faced high levels of sex ratio imbalance—the result of families selectively aborting female fetuses—before completely eliminating this imbalance. The feat is even more remarkable considering that it was accomplished within a single generation.

Before the 1980s, son preference was widespread, but sex ratios were not significantly skewed. Instead, couples were often pressured to continue having children until they bore sons. "I was born in 1961. My parents had five children; I have an older sister and a younger sister, and the last two were boys," Cho recalls. "My mother used to say that if she didn't end up having boys, she would have been abandoned by her mother-in-law."

Patriarchal laws and norms meant that only sons could perform ancestral rites

or inherit their families' fortunes. When daughters married, they were expected to support the rituals of their in-laws rather than their own families. "My grandmother used to scold my parents, 'Why do you invest in the girls? The girls are useless when they get married'," Cho says.

As the country underwent rapid development, household income increased, education expanded and health improved. The Government also created tax and housing incentives to encourage smaller families. By the 1980s, "people were better off," says Dr. Eun Ha Chang, a director at the Korean Women's Development Institute, a government research body. At the same time, "they were introduced to fetal sex screening technology."

Abortion had long been illegal, "but in reality, abortion was very much common among women," Cho explains. "I know many of my friends had to have abortions because of their parents-in-law... It was a kind of control over women's bodies, but they didn't recognize it as a violation of women's choice at that time. The general public just agreed and accepted."

Driven by sex-selective abortion, the country's sex ratio grew increasingly skewed in favour of boys. Alarmed, officials banned prenatal sex testing in 1987 and released a public awareness campaign about the dangers of the girl shortage in the 1990s. Yet the imbalance only continued to grow. By 1994, 115.4 boys were born for every 100 girls.

But the cultural preference for sons began to disappear. One key factor, Chang explains, was the transformation of the economy from a rural agrarian one to an urban, industrial one. "Sons are usually more preferred in agrarian societies," she says. Also crucial were the investments being made in women's and girls' education, "which led to women's consciousness about gender equality... the very strong women's movement in South Korea then triggered changes in laws and policies."

Cho's own experience bears this out. "I entered university in the 1980s. It was a radical environment in all the universities. I studied social science, and I realized the structure and root causes" of son preference. She went on to work with women's groups that, together, pushed for a raft of policy changes. The 1980s and 1990s saw dramatic reforms, including laws that granted inheritance rights to women, laws taking on employment discrimination and domestic violence, and eventually, in 2005, legal changes enabling women to serve as the heads of their households.

Kyung-Jin Oh, a young coordinator at KWAU, saw the last vestiges of son preference as she was growing up in the 1990s. Her mother was the object of pity for not having sons, she recalls. "People said to my mom, 'Oh, you have three children already, but you have only girls. What are you going to do?'"

Girls were also a minority in her elementary school classes: "If there were 50 students in a classroom, we saw that 30 would be boys and 20 would be girls." Today, the echoes of sex ratio imbalance can be felt in the attitudes of some men facing a disproportionately small dating pool of women, she says. "Many men

feel frustrated that they do not have their own female partners to get married to or to date." In the worst cases, these frustrations can result in gender-based violence. "We also see some killings of women," she says.

Oh is inspired to follow in the footsteps of the activists who came before her. "I have a lot of respect for our senior feminists. Korea was very poor, and we didn't have an established democracy. There were so many agendas worth fighting for: for example, human rights, democracy and economic development. It must have been very difficult for activists to focus on women's rights issues. You can see now we have a fruitful and active women's rights movement across the country, but we would not without the legal legacy and experiences of the older women's movement."

Today, the sex ratio of babies born in the Republic of Korea has reached natural levels, and a vibrant new generation of feminists has entered the national stage. These younger activists are battling new forms of gender-based violence, such as the proliferation of spy cams used to create and distribute non-consensual pornography, and they are challenging conventional beauty norms with the #EscapeTheCorset movement.

"They are more vocal," says Chang. "Girls as young as middle school students are actively involved in the #MeToo movement... We're watching carefully how this young feminist movement will lead to the future."

Cho agrees. "The young generation, they can take over. They can use their technology and their new ideas, and they can change all things."

It occurred first in countries or social classes where couples wanted smaller families and had access to technologies such as ultrasound imaging and to private reproductive health care. Later, the practice spread to other countries or social classes as incomes rose.

Because fertility rates are unlikely to rise and because access to technology will likely increase, key drivers of gender-biased sex selection will remain in place for the foreseeable future. Meanwhile, laws and policies that aim to end sex-selective abortions have not been effective in stopping them. Therefore, the solutions to gender-biased sex selection likely lie in tackling the preference for sons through changes in social norms.

Son preference and kinship patterns

Economists might view son preference as investing in a boy's future over a girl's future, assuming the former will yield greater returns. Couples in many parts of the world share that view, believing that a son can bring economic security to the family, particularly when parents become elderly. In contrast, daughters may be seen primarily as costs with few benefits.

Anthropologists would view son preference through a very different lens, one that focuses on family systems and local gender contexts (Den Boer and Hudson, 2017; Guilmoto, 2012; Murphy and others, 2011; John and others, 2008; Bélanger, 2002). To them, son preference is linked to kinship patterns. In parts of the world where kinship systems are more balanced, such as in South-East Asia and

Latin America, parents generally see equal value in daughters and sons, sometimes favouring girls over boys (Das Gupta and others, 2003; Croll, 2000; Dube, 1997).

A society that places higher value on sons may be one where inheritance of land is patrilineal, where support in old age is provided by sons, and where a woman who marries must take her husband's name and reside with or near her husband's family. Such systems in many rural societies are also supported by, or reflected in, norms and customs related to family honour, respect for parents and authority, and religious beliefs, including those related to the afterlife (Alesina and Giuliano, 2014).

Artwork courtesy of Fatma Mahmoud Salama Raslan

Patrilineal and patrilocal systems invariably promote boys as the future for a family and teach girls that their futures will eventually depend on their husbands. A girl's transient status from dependence on her own family to dependence on her husband and his family reduces her social worth and her contribution to her birth family. Social behaviour is structured by these norms and customs and encourages parents and communities to produce sons to ensure the continuation of the family line.

Deviation from local norms comes with risks. In patrilineal and patrilocal settings, the failure to produce a male heir may undermine a family's or a woman's social, political and economic status. To avoid exclusion or marginalization, families may opt to abide by the established kinship rules, which rationalize gender-biased sex selection as an accepted means to avoid having daughters.

Demographic impact

More than 140 million females are considered missing today as a consequence not only of gender-biased sex selection but also of postnatal sex selection (Table 3.3) (Bongaarts and Guilmoto, 2015).

Sex selection can distort the composition of a country's population for generations. The most obvious and immediate effect is the rise in the sex ratio at birth. Over time, these skewed ratios translate into missing girls, missing women and missing elderly women.

Son preference manifested in sex selection has led to dramatic, long-term shifts in the proportions of women and men in the populations of some countries. For example, imbalances in the sex ratio at birth in China and India were first observed in the 1980s. Today, the proportion of males under the age of 35 is 11 per cent larger than the proportion of females in these countries. One study suggests that a portion of China's skewed sex ratio may also be attributed to some underreporting of births of girls or their delayed registration (Shi and Kennedy, 2016).

This demographic imbalance will have an inevitable impact on marriage systems. In countries where marriage is nearly universal, many men may need to delay or forego marriage because they will be unable to find a spouse. This so-called "marriage squeeze", where prospective grooms outnumber prospective brides, has already been observed in parts of China and India and affects mostly young men

MORE THAN 140 MILLION FEMALES ARE CONSIDERED MISSING TODAY as a consequence not only of gender-biased sex selection but also of postnatal sex selection.

from lower economic strata. At the same time, the marriage squeeze could result in more child marriages (Srinivasan and Li, 2017).

Some studies suggest that the marriage squeeze will peak in China between 2030 and 2055, and in India in 2055 (Guilmoto, 2012a). The proportion of men who are still single at the age of 50 is forecast to rise after 2050 in China and India, to 15 and 10 per cent, respectively. Recent research has already observed a rising number of "involuntarily single men" in China and India (Srinivasan and Li, 2017; Kaur, 2016).

The effects of sex ratio imbalances ripple throughout societies and help perpetuate the gender inequality that led to them in the first place (UNFPA, 2012; Sen, 2009).

Toll on human rights

Gender-biased sex selection not only perpetuates gender inequality, it can also override women's reproductive autonomy.

For women in some countries or communities where sons are preferred over daughters, technological breakthroughs such as ultrasound imaging do not enhance reproductive health and rights, but instead transform choices into obligations (Gammeltoft and Wahlberg, 2014). Societal pressures may lead women to terminate pregnancies against their will. In some cases, a woman who refuses to accede to societal expectations may endure physical violence, social exclusion and divorce.

Societal pressures on couples to have sons may also pressure women to have more pregnancies than they desire, denying their right to freely and responsibly make their own decisions about the timing and spacing of pregnancies.

Sex ratio imbalances and the marriage squeezes that result from them can exacerbate problems of gender-based violence, including rape, coerced sex, sexual exploitation, trafficking and child marriage—all of which are human rights violations (South and others, 2014; Tucker and others, 2005; Hudson and den Boer, 2004).

Breaking the cycle

Over the years, governments have implemented policies aimed at ending son preference in general and gender-biased and postnatal sex selection in particular, with mixed results (Rahm, 2020).

Banned and prohibited

Almost all countries where son preference is prevalent have banned sex-selective abortions or procedures that lead to them. The reasons for seeking any abortion, however, are numerous and complex, so it is difficult, if not impossible, to know which are sought explicitly for sex selection and which are sought for other reasons.

Countries such as the Republic of Korea and Viet Nam have prohibited doctors from disclosing the sex of the fetus during antenatal care visits. However, antenatal visits that include ultrasound screening are now commonplace and often take place in private practices, where people may pay physicians to reveal the sex or where physicians may indirectly or discreetly provide the information. As technology advances, new methods such as fetal blood tests

for determining the sex of a fetus may emerge, making it easier to obtain this information. Still other technologies that will allow sex selection before in vitro fertilizations will further complicate enforcement of sex-selection laws. Overall, bans on sex selection are often ineffective and also infringe reproductive rights, including access to safe abortion in countries where abortion is legal (Ganatra, 2008).

Educating on the harm

Other actions taken by governments, particularly in Asia, include measures to educate the public about the impact of families' reproductive decisions on society as a whole. Early campaigns focused on raising awareness about how sex selection discriminates against girls. Later campaigns focused on how gender-biased sex selection results in marriage squeezes. It may take decades, however, for such campaigns to change attitudes and behaviours. Furthermore, these campaigns may not be effective in reaching wealthier families that practise gender-biased sex selection since they are less likely to be affected by the marriage squeeze. Men who are more advantaged will still be able to marry. Conversely, men from lower socioeconomic groups, where gender-biased sex selection is less likely to be practised because of prohibitive costs, are more likely to be affected by the marriage squeeze (Srinivasan and Li, 2017; Kaur, 2016).

Ushering in gender-equal norms

Governments have also taken action to address the root causes of sex selection. Interventions implemented, for example, in China, India and Viet Nam have included campaigns that target gender stereotypes to change attitudes and open the door to new norms and behaviours. They spotlight the importance of daughters and highlight how girls and women have changed society for the better. Campaigns that celebrate women's progress and achievements may resonate more where daughter-only families can be shown to be prospering.

Other interventions include policies and laws that aim to put women and men—and girls and boys—on an equal footing, in areas ranging from property inheritance and land rights, to political participation, paid employment and pension rights (Den Boer and Hudson, 2017).

Because son preference is inextricably tied to gender inequality, actions that aim to promote equal rights and opportunities for women and men and girls and boys may be part of the solution. Addressing gender bias through the "three As" of assets, autonomy and ageing is key (Brahme, 2016). This means guaranteeing women the same rights as men to property ownership and inheritance, respecting women's and girls' rights to make their own decisions in all spheres of life, and changing attitudes that only men are capable of supporting parents as they grow older.

The Republic of Korea launched information and advocacy campaigns to bolster girls' status and to discourage gender-biased sex selection, and at the same time overhauled policies banning disclosure of fetal sex. The country saw a reduction in the sex ratio at birth, but it is unclear whether these efforts alone reduced son preference or if social change, notably increased women's access to education and employment, was responsible (Chung and Das Gupta, 2007). Georgia, which did not

introduce specific policies regarding gender-biased sex selection, also saw a sustained decline in the sex ratio at birth, for which economic development measures may be chiefly responsible (UNFPA, 2017).

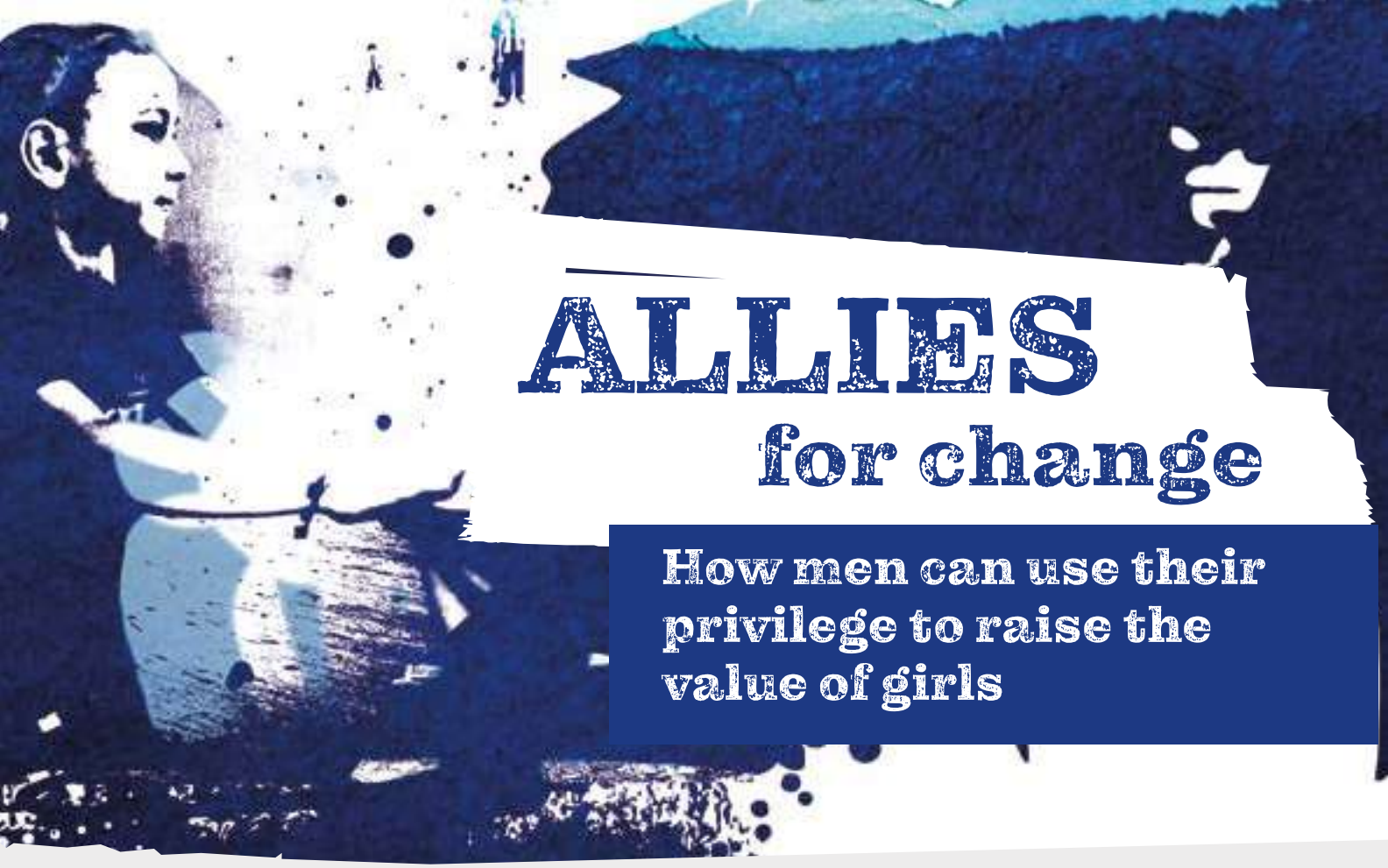
A world where sons and daughters are equally valued

Consensus on the pressing need for change is both broad—as in the call for gender equality in Sustainable Development Goal 5—and specific, as in the 2011 United Nations inter-agency statement, "Preventing Gender-biased Sex Selection". Commitments by countries to tackle son preference, the perceived low value of girls and gender inequalities are critical. For example, partnerships through a UNFPA programme are exchanging knowledge and experience across societies that share the same harmful practices—Bangladesh, Nepal and Viet Nam in Asia and Armenia, Azerbaijan and Georgia in the Caucasus. Solutions are found in approaches that are neither judgmental nor coercive but encourage positive behaviour change and are supportive of women and girls without compromising their reproductive rights. Change is imperative, as the United Nations statement concludes: "Imbalanced sex ratios are an unacceptable manifestation of gender discrimination against girls and women and a violation of their human rights."

Early in his life, Janoghlan Ilyasov struggled with expressing himself. To overcome these challenges, he took up public speaking and eventually excelled—in 2010, he was named Azerbaijan's Best Orator.

Seven years after he found his own voice, he started speaking up for women and girls and for the protection of their rights, through a UNFPA-supported community outreach initiative, which is part of the Government's national action plan to end gender-biased sex selection in the country.

"The youth in our country are raised with the understanding that men are the decision makers in the home. I knew that it was important to change the hearts and minds of these future fathers," Ilyasov says.



ALLIES for change

How men can use their privilege to raise the value of girls

The deeply rooted preference for sons in the country is linked to structural factors that reinforce the notion that boys are more socially and economically valuable than girls: inheritance and land rights traditionally pass through male heirs, for instance, and ageing parents typically rely on financial support from sons. Social norms dictate that only sons can ensure the continuation of a family lineage.

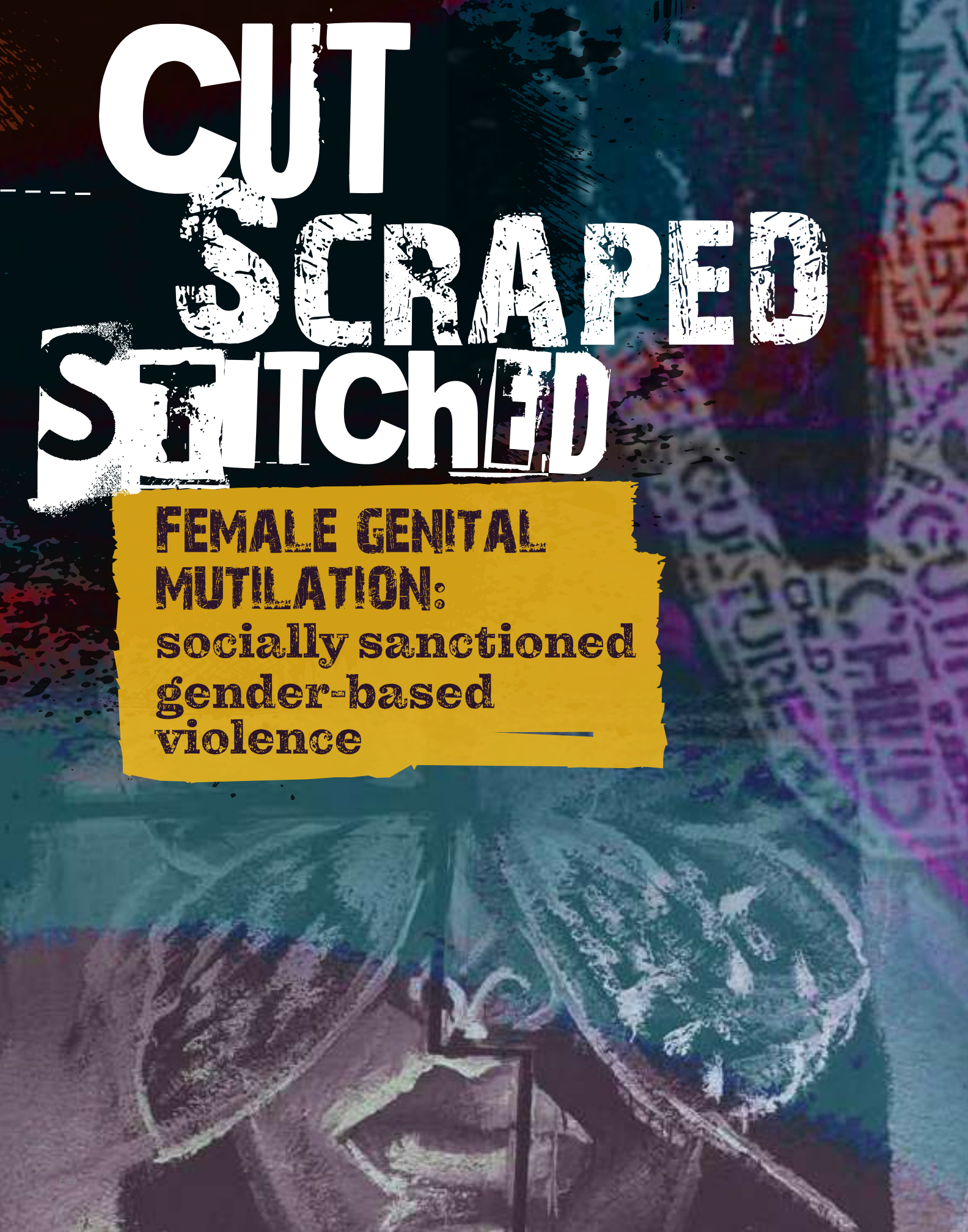
Until the early 1990s, the country had a typical sex ratio at birth—about 106 boys for every 100 girls. But by 2003 the ratio rose dramatically, hitting 118 boys per 100 girls, according to data from the UNFPA office in Azerbaijan.

Because young men hold so much power and privilege in their families, they are able to play an important role in promoting gender equality and thus have the power to shift norms for son preference. In the workshops he leads, Ilyasov encourages men to examine their attitudes towards women and girls and helps them understand how son preference is a reflection of gender inequality. "Even the most rigid men reconsider their deep-seated beliefs during these sessions," he says.

"I have a one-year-old daughter of my own," he adds. "I make a point to spend time with her every day. Even though she is very small, I talk with her. When you talk and listen to your daughter, you are telling her she is important, that she matters. You are teaching her the power of her own voice."

CUT SCRAPED STITCHED

FEMALE GENITAL MUTILATION: socially sanctioned gender-based violence



Female genital mutilation (FGM) is a harmful practice exclusively directed towards women and girls that violates their fundamental rights—to health, to bodily integrity, to be free from discrimination and from cruel or degrading treatment.

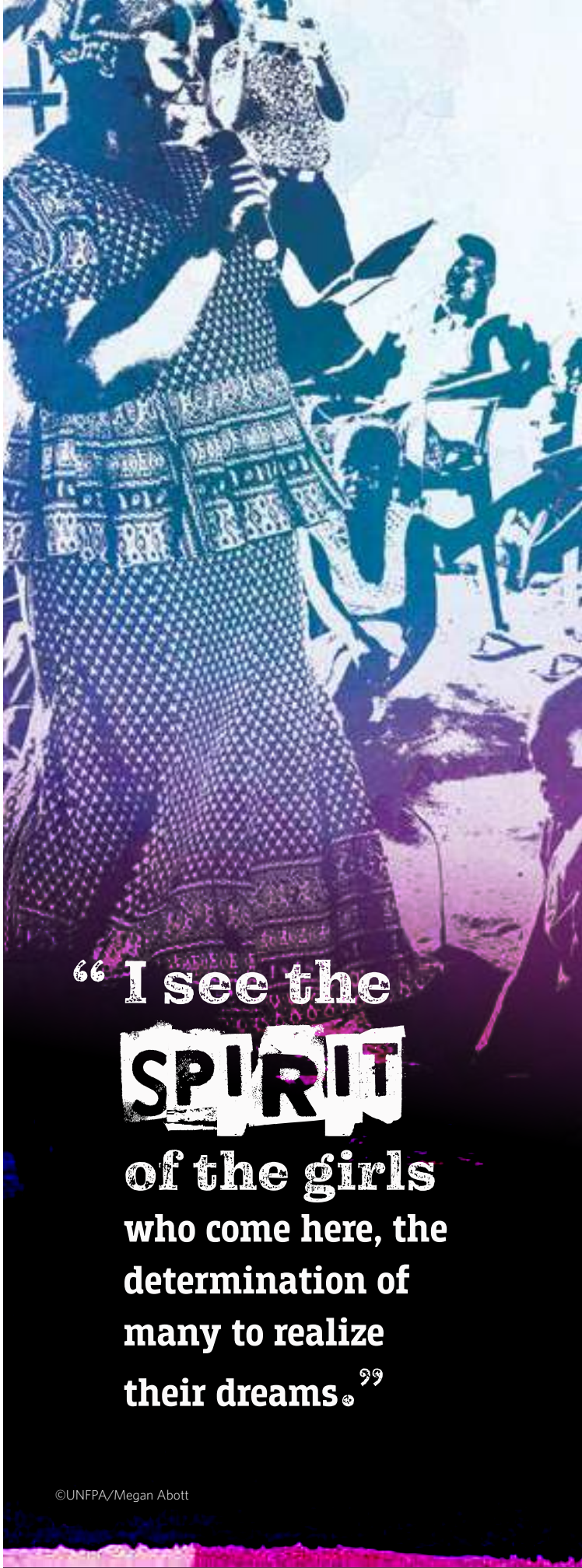
Action to end this harmful practice is driving down already declining rates. Women and men who oppose the lifelong damage caused by FGM are saying no for their daughters. Yet where populations are growing fast, the sheer number of girls affected is growing too.

FGM can result in severe physical and psychological harm. It can cause painful intercourse, infection, cysts and infertility and can heighten the risk of HIV, obstetric fistula, complications giving birth and newborn mortality. It can also trigger depression, nightmares, panic and trauma. Regardless of *why* it is done, a girl can be harmed for life.

Global human rights instruments unequivocally condemn FGM, yet 4.1 million girls and women are at risk of being subjected to it in 2020 alone. Some 200 million girls and women alive today have undergone some form of genital mutilation in 31 countries—suffering not only in the moment but also from a lack of support and services to meet subsequent ongoing needs for physical and mental health care. The United Nations strives for the practice's full eradication by 2030, under Sustainable Development Goal 5, recognizing the positive effect this would have on the health, dignity, education and economic advancement of girls and women.

Without any medical need

FGM is an invasive procedure on otherwise healthy tissue without any medical need. It entails partial or total removal of the female external genitalia or other injury to female genital organs for non-medical reasons (WHO, 2020), and can range from scraping and cauterizing the genitalia to total removal of the clitoris to sewing the labia together to make the vaginal opening smaller. The procedure is mostly carried out on young girls between infancy and age 15 (WHO, 2020). The "medicalization" of this harmful practice by medical professionals is never justified.



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REFUSING to be SILENCED

Female genital mutilation survivors change their communities from within

Rhobi Samwelly was 13 years old when her mother told her that she would undergo female genital mutilation, FGM, a tradition in her community. She was terrified. "I didn't want it because my friend Sabina had died from it." Samwelly pleaded with her mother not to have her cut, but her mother was insistent, promising Samwelly that she would select a "good cutter" and that she would not die.

But she nearly did. Samwelly bled profusely and was unconscious for hours. When she eventually came around, her mother was so relieved she promised Samwelly she would not cut her six younger sisters.

On that day, an activist was born. Samwelly was angry. She didn't want anybody to experience the pain she had felt, and made it her mission to tell her school friends about the dangers of FGM, urging them to refuse the practice.

After Samwelly married and gave birth to a girl, her third child, she resisted pressure from her husband's family, making it clear that her daughter was not going to be subjected to genital mutilation.

Samwelly founded two safe houses in the Butiama and Serengeti Districts of Tanzania's Mara Region, to shelter and support the courageous girls who run away to avoid FGM during the biannual cutting season. "I see the spirit of the girls who come here, the determination of many to realize their dreams," she said. Because the girls sheltering at Samwelly's safe houses are able to go to school or vocational training, many go on to successful careers. Some are now hotel managers, others want to become doctors, even airline pilots. Samwelly says that their families now look at them with respect and pride.

Fear of the law—FGM has been criminalized in Tanzania since 1998—coupled with increased awareness of the harmful effects of the practice have helped reduce its prevalence, but it persists in some regions, particularly where patriarchal norms are strong and traditional and clan leaders play a central role in decision making. "Traditional leaders still demand that their sons marry someone who is cut," says Samwelly. "There are still widely held beliefs that women who have been cut are more controllable, more likely to remain with their husband and not run off with other men," she adds.

Yet it is not just men who perpetuate the cycle. It remains practised by women who themselves have been cut. "If a mother is not educated, everything in her life is hard. She doesn't realize the benefits of taking her child to school, she is not aware of the dangers of FGM," says Samwelly.

Poverty is also a driving factor. Families who are unable to pay for their daughter's school fees, food or other basic costs see child marriage as a way to ensure her security. The bride price that families receive for their daughter—including cattle, money or other valuables—is also a way to alleviate poverty. In both cases, girls must undergo FGM to prepare them for marriage.

Samwelly says that progress to eliminate the practice by 2030, in line with global development goals, is being made. She has witnessed, in community outreach sessions, practitioners called nagribas laying down their tools and pledging to become champions to end the practice. She has also seen parents change their minds about cutting their daughters. And the law is being enforced—more parents and cutters are being sent to prison. But Samwelly says too many are still walking free and the power of the police and court officials to enforce the law must be increased.

Attitudes towards girls' education need to change. Often, it is not a family's priority.

"If a mother is not educated, everything in her life is hard. She doesn't realize the benefits of taking her child to school, she is not aware of the dangers of FGM."

"Girls are given jobs to do first thing in the morning and then have to walk long distances to school, which makes them vulnerable. They are also tired," Samwelly says. "Many parents are just looking for an excuse to take their daughter out of school and marry her off."

There must be income-generating opportunities for women and girls, and for those who benefit from the practice, such as traditional leaders and cutters. This would enable practitioners to stop, and it would empower women who are currently afraid to stand up to social norms. Samwelly says that, too often, mothers are unable to help their daughters escape genital mutilation because they are worried that they will be beaten or thrown out of the marital home. "Without any source of income or economic independence, they keep quiet," she explains.

Awareness-raising activities also need to be stepped up so that families and communities are aware of the harmful impacts of FGM. In many places, these efforts are already bearing fruit. "Girls are saying no to cutting, and some boys do not want to marry a girl who has been cut —they are aware of its effects on women, including the difficulties women experience during childbirth," says Samwelly.

If FGM is put high on the agenda, and if leaders are called upon to listen to the voices of empowered girls, Samwelly says she is hopeful that the practice can be consigned to history within a generation.

Roots in gender inequality

FGM is grounded in beliefs that it improves fertility, enhances sexual pleasure for men, suppresses female sexuality, leads to better hygiene, prevents infidelity, complies with the demands of religious institutions or results in acceptance by the community (Kandala and others, 2019; Alhassan and others, 2016; Ashimi and others, 2015; Bogale and others, 2014). It is believed to uphold a girl's purity, honour and cleanliness, and it is used to control women's sexuality as a way to make girls and women more marriageable, conforming to social norms that have sustained the practice for centuries (Mackie, 2009).

FGM is socially sanctioned gender-based violence. Although the act itself is usually performed by older women, it is a patriarchal practice rooted in unequal power relations between women and men, embedded in a system that sustains men's power (UN Women, 2017).

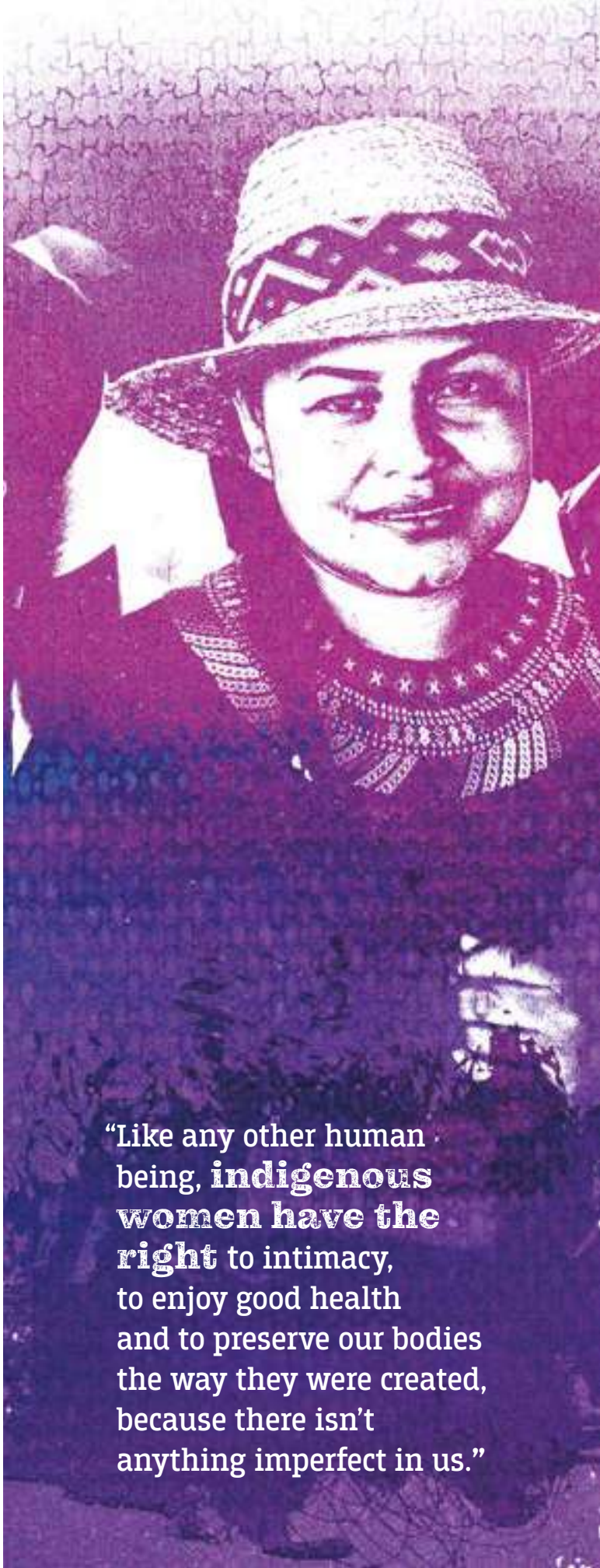
Empowering women—and men—to say no for their daughters would be transformational, but they need the agency and information to make a different choice. In almost every context, parents believe that the practice is the right thing to do for their daughters. In many cases, parents are aware of the physical and psychological risks but do it in the interest of social acceptance (Eldin and others, 2018; Tamire and Molla, 2013). Mothers are often the ones who subject daughters to FGM, perpetuating gender-unequal norms that drive the practice from one generation to the next.

Practised in all regions

FGM is concentrated in the African continent, from the Atlantic coast to the Horn of Africa, but is also prevalent in countries such as Iraq and Yemen, and in some Asian countries, such as Indonesia, where, according to one estimate, 49 per cent of girls aged 11 or younger have been subjected to FGM (Indonesia, 2013) (Figure 4.1). With record levels of migration in the past decade, this harmful practice is no longer restricted to countries in the global South.

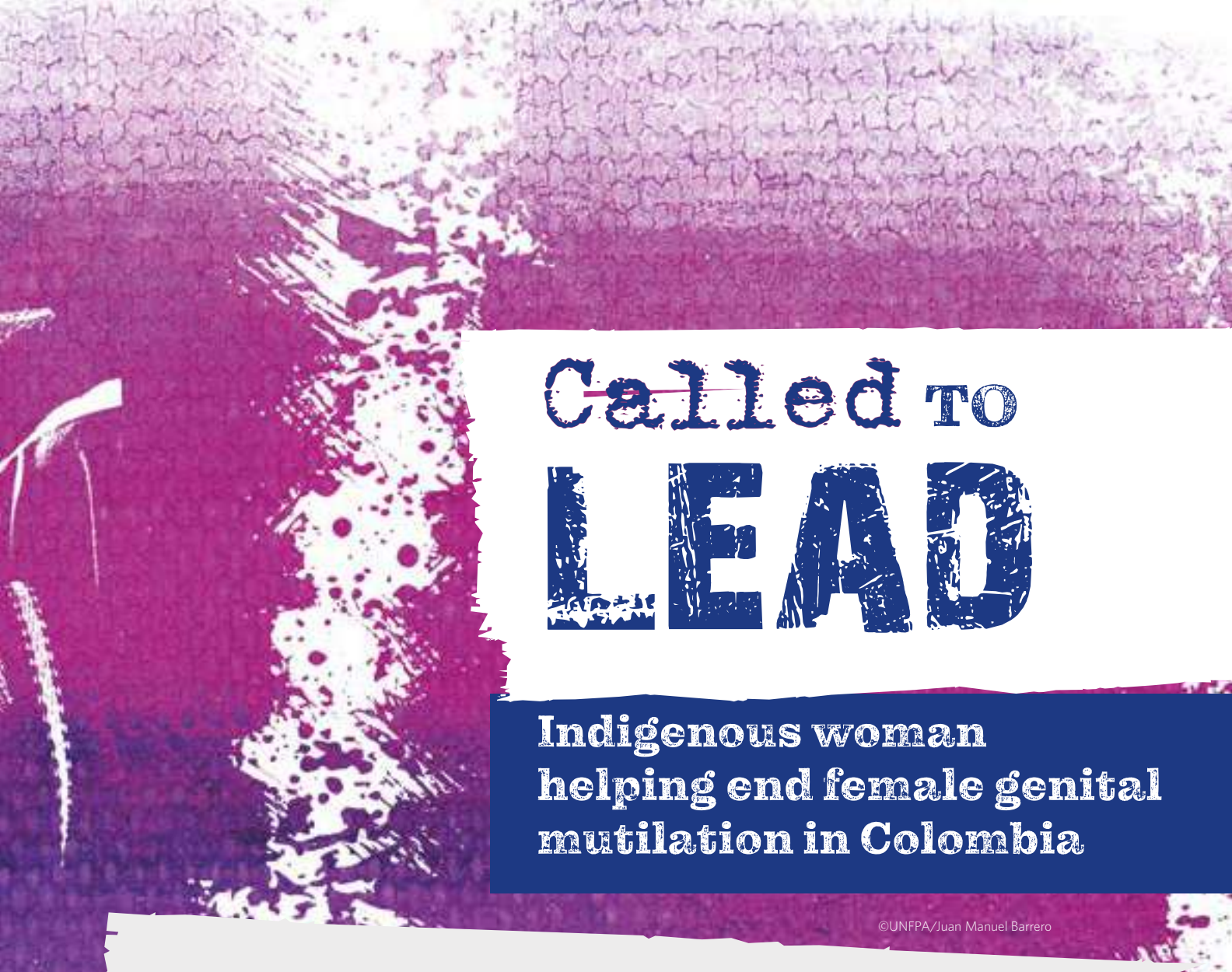
The latest available data show that the proportion of women aged 15 to 49 who have been subjected to FGM ranges from about 1 per cent in Cameroon (as of 2004) and Uganda (as of 2011), to 90 per cent or more in Djibouti (as of 2006), Egypt (as of 2015), Guinea (as of 2018) and Mali (as of 2018).

FGM is also found, for example, in Australia, the European Union, Japan, New Zealand, the United Kingdom and the United States. The United States Centers for Disease Control and Prevention estimated that 513,000 girls and women in the United States were at risk of, or had been subjected to, FGM in 2012, attributing the change primarily to increased immigration from countries where it is practised (Goldberg and others, 2016). This is a threefold increase from the previous estimate in 1990. In England and Wales, as of 2015, an estimated 137,000 girls had undergone FGM (Macfarlane and Dorkenoo, 2015). In Australia, an estimated 50,000 had been subjected to the practice as of 2017 (Australian Institute of Health and Welfare, 2019).



Called to LEAD

Indigenous woman helping end female genital mutilation in Colombia



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When Arelis Cortés was growing up in the Cauca Valley of western Colombia, she saw how older women had been denied the right to read, write or be heard. One day, an older woman in their Embera Chamí community asked her to make a difference—so she did. At 15 years old, she began speaking out about women's and girls' rights. Today, she stands at the forefront of efforts to end female genital mutilation (FGM), which is practised by some members of the indigenous community.

"Like any other human being, indigenous women have the right to intimacy, to enjoy good health and to preserve our bodies the way they were created, because there isn't anything imperfect in us," says Cortés, now 28, speaking to a group of women attending a community meeting under the hot sun.

In Colombia, there are no official statistics on the number of women and girls who have experienced FGM. Often, the cases are not uncovered until a girl arrives at a health facility, seriously injured from the practice. Some girls have died.

According to Cortés and the region's indigenous authorities, the practice was introduced in colonial times, and it is not established in their native law. Leaders suggest, as one of different possible explanations, it was imposed to prevent women's infidelity by tamping down their sexual desires. It is not universally practised but persists, often in secret, in the form of clitoridectomy, locally called "the healing".

In 2015, indigenous authorities signed a mandate to end FGM. Since then, Cortés has worked with the Cauca Valley Indigenous Regional Organization, in the Colombian Pacific Region, travelling to different territories to speak directly to communities about the harms of FGM. She raises the issues alongside messages about women's and girls' human rights.

> "We work with women in those territories to make them aware of the importance of ENDING THIS PRACTICE..."

"It hasn't been easy. I must take an eight- or nine-hour drive to get to distant communities, but the training experience has benefited women significantly," says Cortés.

She also conducts training for traditional birth attendants and pregnant women on sexual and reproductive health issues, helping them value the integrity of girls' bodies.

"We work with women in those territories to make them aware of the importance of ending this practice and, above all, that we must respect the lives, rights and intimacy of the women and girls we work for," she says.

Cortés says that shining a light on this harmful practice initially came with a cost: indigenous communities felt attacked by the outside world. "When we began working to prevent this violation of women's rights, we were harshly criticized and shamed for having this practice in our communities," she remembers.

She and her fellow advocates worked to show that FGM was simply the result of a lack of information, and that, with sufficient resources, indigenous communities could come together to abandon the practice.

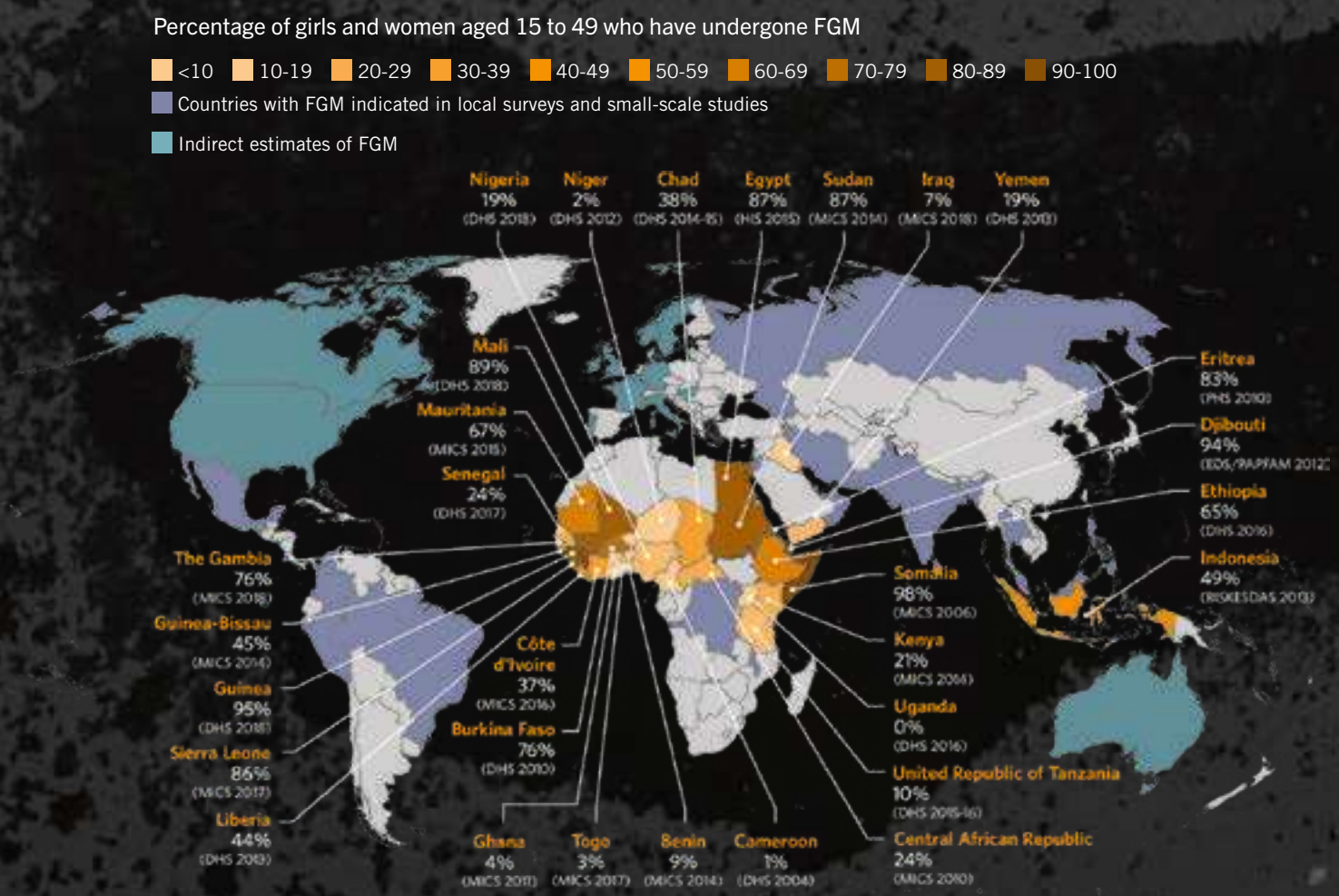
Cortés says this is exactly what is happening. A consortium of indigenous authorities and Embera Chamí organizations has been working to end FGM since 2007. That, together with the empowerment of women and girls, is making a difference.

Soon, she says, FGM "will become a thing of the past."

There have also been reports of FGM over the past decade in Colombia (UNFPA, 2011a), Malaysia (Dahlui, 2012), Oman (Al-Hinai, 2014), Saudi Arabia (Alsibiani and Rouzi, 2010) and the United Arab Emirates (Kvello and Sayed, 2002), with significant variations in the type of FGM performed.

A 2015 study by the European Institute for Gender Equality estimated that as many as 1,600 girls in Ireland, 1,300 girls in Portugal and 11,000 girls in Sweden may have been subjected to FGM in 2011 (EIGE, 2015). Later estimates suggest thousands of girls were subjected to FGM in Belgium, Germany, Italy and the Netherlands (EIGE, 2019).

FIGURE 4.1 **The prevalence of female genital mutilation (FGM) varies greatly across countries with data**



Based on Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other national surveys, 2004-2018.

Notes: Data for Indonesia refer to girls aged 0 to 11 years since prevalence data on FGM among girls and women aged 15 to 49 years are not available. The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

Harm with many dimensions

FGM is a procedure with no health benefits, but immediate and long-term health consequences, ranging from infection to disabilities that last a lifetime (Table 4.1). Some forms increase the risk of poor obstetric outcomes, perinatal mortality, caesarean section and post-partum bleeding (Gebremicheal and others, 2018; Berg and others, 2014, 2014a, 2010; WHO, 2006, 2000; WHO, n.d.). In terms of sexual health, studies show impaired sexual function in women who have undergone FGM (Johnson-Agbakwu and Warren, 2017; Abdulcadir and others, 2016; Mahmoud, 2016; Mohammed and others, 2014; Ibrahim and others, 2013; Berg and others, 2010; Banks and others, 2006; Thabet and Thabet, 2003; Vangen and others, 2002; Ismail, 1999).

TABLE 4.1 **All forms of female genital mutilation (FGM) increase health risks in the short and long term**

SHORT-TERM HEALTH RISKS	
Severe pain	Cutting the nerve ends and sensitive genital tissue causes extreme pain. The healing period is also painful
Excessive bleeding (haemorrhage)	Can result if the clitoral artery or other blood vessel is cut
Shock	Can be caused by pain, infection and/or haemorrhage
Genital tissue swelling	Due to an inflammatory response or local infection
Infections	May spread after the use of contaminated instruments (e.g. use of same instruments in multiple genital mutilation operations), and during the healing period
HIV infection	The direct association between FGM and HIV remains unconfirmed, although the cutting of genital tissues with the same surgical instrument without sterilization could increase the risk for transmission of HIV between girls who undergo FGM together
Urination problems	These may include urine retention and pain passing urine. This may be due to tissue swelling, pain or injury to the urethra
Impaired wound healing	Can lead to pain, infections and abnormal scarring
Death	Death can result from infections, including tetanus, as well as haemorrhage that can lead to shock
Mental health problems	The pain, shock and use of physical force during the event, as well as a sense of betrayal when family members condone and/or organize the practice, are reasons why many women describe FGM as a traumatic event

LONG-TERM HEALTH RISKS

Pain	Due to tissue damage and scarring that may result in trapped or unprotected nerve endings
Chronic genital infections	With consequent chronic pain, and vaginal discharge and itching. Cysts, abscesses and genital ulcers may also appear
Chronic reproductive tract infections	May cause chronic back and pelvic pain
Urinary tract infections	If not treated, such infections can ascend to the kidneys, potentially resulting in renal failure, septicaemia and death. An increased risk of repeated urinary tract infections is well documented in both girls and adult women who have undergone FGM
Painful urination	Due to obstruction of the urethra and recurrent urinary tract infections
Vaginal problems	Discharge, itching, bacterial vaginosis and other infections
Menstrual problems	Obstruction of the vaginal opening may lead to painful menstruation (dysmenorrhoea), irregular menses and difficulty in passing menstrual blood, particularly among women with type III FGM
Excessive scar tissue (keloids)	Excessive scar tissue can form at the site of the cutting
HIV infection	Given that the transmission of HIV is facilitated through trauma to the vaginal epithelium, which allows the direct introduction of the virus, it is reasonable to presume that the risk of HIV transmission may be increased as a result of FGM due to the increased risk of bleeding during intercourse
Sexual health problems	FGM damages anatomical structures that are directly involved in female sexual function and can therefore also have an effect on women's sexual health and well-being. Removal of, or damage to, highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual desire and pleasure, pain during sex, difficulty during penetration, decreased lubrication during intercourse and reduced frequency or absence of orgasm (anorgasmia). Scar formation, pain and traumatic memories associated with the procedure can also lead to such problems
Childbirth complications (obstetric complications)	FGM is associated with an increased risk of caesarean section, post-partum haemorrhage, recourse to episiotomy, difficult and/or prolonged labour, obstetric tears/lacerations, instrumental delivery and extended maternal hospital stay. The risks increase with the severity of FGM
Obstetric fistula	A direct association between FGM and obstetric fistula has not been established. However, given the causal relationship between prolonged and obstructed labour and fistula, and the fact that FGM is also associated with prolonged and obstructed labour, it is reasonable to presume that both conditions could be linked in women living with FGM
Perinatal risks	Obstetric complications can result in a higher incidence of infant resuscitation at delivery and intrapartum stillbirth and neonatal death
Mental health problems	Studies have shown that girls and women who have undergone FGM are more likely to experience post-traumatic stress disorder, anxiety disorders, depression and somatic (physical) complaints, such as aches and pains, with no organic cause

Women who have been subjected to FGM are more likely to develop psychological disorders, such as depression, recurring nightmares, loss of appetite, panic attacks, trauma, anxiety, somatization, phobias and low self-esteem (Piroozi and others, 2020; Zayed and Ali, 2012; Kizilhan, 2011; Vloeberghs and others, 2011; Elnashar and Abdelhady, 2007; Behrendt and Moritz, 2005; Osinowo and Taiwo, 2003).

Poor, rural and less-educated girls are most at risk

FGM is generally more prevalent among poorer households in rural areas than in wealthier urban households (Figure 4.2). In Egypt, for example, more than 90 per cent of women in rural areas have undergone FGM compared with 77 per cent of women in urban areas (as of 2015). In Kenya, women in rural areas are almost twice as likely compared with women in urban areas (as of 2014).

Studies in Burkina Faso, Egypt and Ethiopia have shown that women who reside in rural areas are more likely to have undergone FGM or be willing to practice FGM on their daughters—and at the same time, they have more favourable attitudes towards FGM compared with those who reside in urban areas (Mohammed and others, 2014; Tamire and Molla, 2013; UNICEF, 2012, 2010; Karmaker and others, 2011).

In Mauritania, more than 90 per cent of women from the poorest households have had some form of FGM, compared with 37 per cent of women from richest households. Exceptions include Burkina Faso, where the prevalence is 18 per cent in the poorest households and 36 per cent in the wealthiest households.

Quantitative evidence that shows an association between FGM and girls' educational attainment is limited, as studies have tended to rely on anecdotes or non-representative samples (ICRW, 2016). However, in Kenya, evidence suggests a relationship between FGM and dropping out of school and between FGM and lower participation in school-related activities (Nyabero and others, 2016; Magangi, 2015; Blessing and Sironko, 2014). Several quantitative studies in Burkina Faso, Egypt, Iran, Nigeria and Yemen showed low education levels of the mother significantly predicted women and girls who had undergone FGM (Dehghankhalili and others, 2015; Ahanonu and Victor, 2014; Mohammed and others, 2014; Al-Khulaidi and others, 2013; Modrek and Liu, 2013; Hayford and Trinitapoli, 2011; Karmaker and others, 2011).

"I was first because I was the oldest. I was told to open my knees, so I opened them. I bled. I fainted. But I am so lucky I am alive, because so many girls die from this."

FIGURE 4.2

Prevalence of female genital mutilation (FGM) among girls and women aged 15 to 49 years, by urban/rural residence and wealth quintile (%)

	FGM prevalence girls and women (%)	RESIDENCE		WEALTH QUINTILE	REF YEAR	DATA SOURCE
		Urban	Rural	Poorest · Second · Middle · Fourth · Richest		
Benin	9	5	13		2014	MICS
Burkina Faso	76	69	78		2010	DHS/MICS
Cameroon	1	1	2		2004	DHS
Central African Republic	24	18	29		2010	MICS
Chad	38	40	38		2014-15	DHS
Côte d'Ivoire	37	31	44		2016	MICS
Djibouti	94	94	98		2012	EDSF/PAPFAM
Egypt	87	77	93		2015	Health Issues Survey (DHS)
Eritrea	83	80	85		2010	Population and Health Survey
Ethiopia	65	54	68		2016	DHS
Gambia	76	77	72		2018	MICS
Ghana	4	3	5		2011	MICS
Guinea	95	95	94		2018	DHS
Guinea-Bissau	45	40	50		2014	MICS
Iraq	7	7	8		2018	MICS
Kenya	21	14	26		2014	DHS
Liberia	44	37	56		2013	DHS
Mali	89	89	88		2018	DHS
Maldives	13	14	12		2016-17	DHS
Mauritania	67	55	79		2015	MICS
Niger	2	1	2		2012	DHS
Nigeria	19	24	16		2018	DHS
Senegal	24	20	28		2017	DHS
Sierra Leone	86	80	92		2017	MICS
Somalia	98	97	98		2006	MICS
Sudan	87	85	87		2014	MICS
Togo	3	3	4		2017	MICS
Uganda	0	0	0		2016	DHS
United Republic of Tanzania	10	5	13		2015-16	DHS
Yemen	19	17	19		2013	DHS

Indicator definition: Percentage of girls and women aged 15 to 49 years who have undergone FGM.

Notes: In Liberia, only girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM, since it is performed during initiation into the society.

Source: UNICEF global databases 2020, based on Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other nationally representative surveys.

Trends show a decline, but more girls are affected

The *proportion* of women and girls subjected to FGM is decreasing overall, but the *number* of women and girls subjected to it is growing because of population growth. That number could grow from 4.1 million in 2020 to 4.6 million a year by 2030, since the cohort of girls in many high-prevalence countries is growing.

The proportion of women and girls subjected to FGM has been declining for years. Data trends extrapolated from 30 countries show that in the late 1980s an estimated one in two girls aged 15 to 19 underwent FGM. In those same countries today, this has declined to an estimated one in three (UNICEF, 2020a).

Reliable data can help governments track progress towards the elimination of FGM, inform future policies and interventions and help identify where support for communities is needed most.

Nationally representative data on FGM are mainly available from two sources: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS). Data on FGM have been collected through DHS since 1990 and through MICS since 2000 (UNFPA, 2015). While these surveys have yielded insights into the scope and location of the practice, analysis of the data emerging from them is not always straightforward, and there are concerns about the reliability of data on self-reported FGM in MICS and DHS that are not verified through clinical examinations.

Opposition is building

Opposition to FGM is building, propelling momentum to abandon this harmful practice. In the past two decades, the proportion of girls and women in high-prevalence countries who want the practice to stop has doubled (UNICEF, 2020). As more and more women, girls, men and boys learn about FGM and its harm, opposition to the practice is growing.

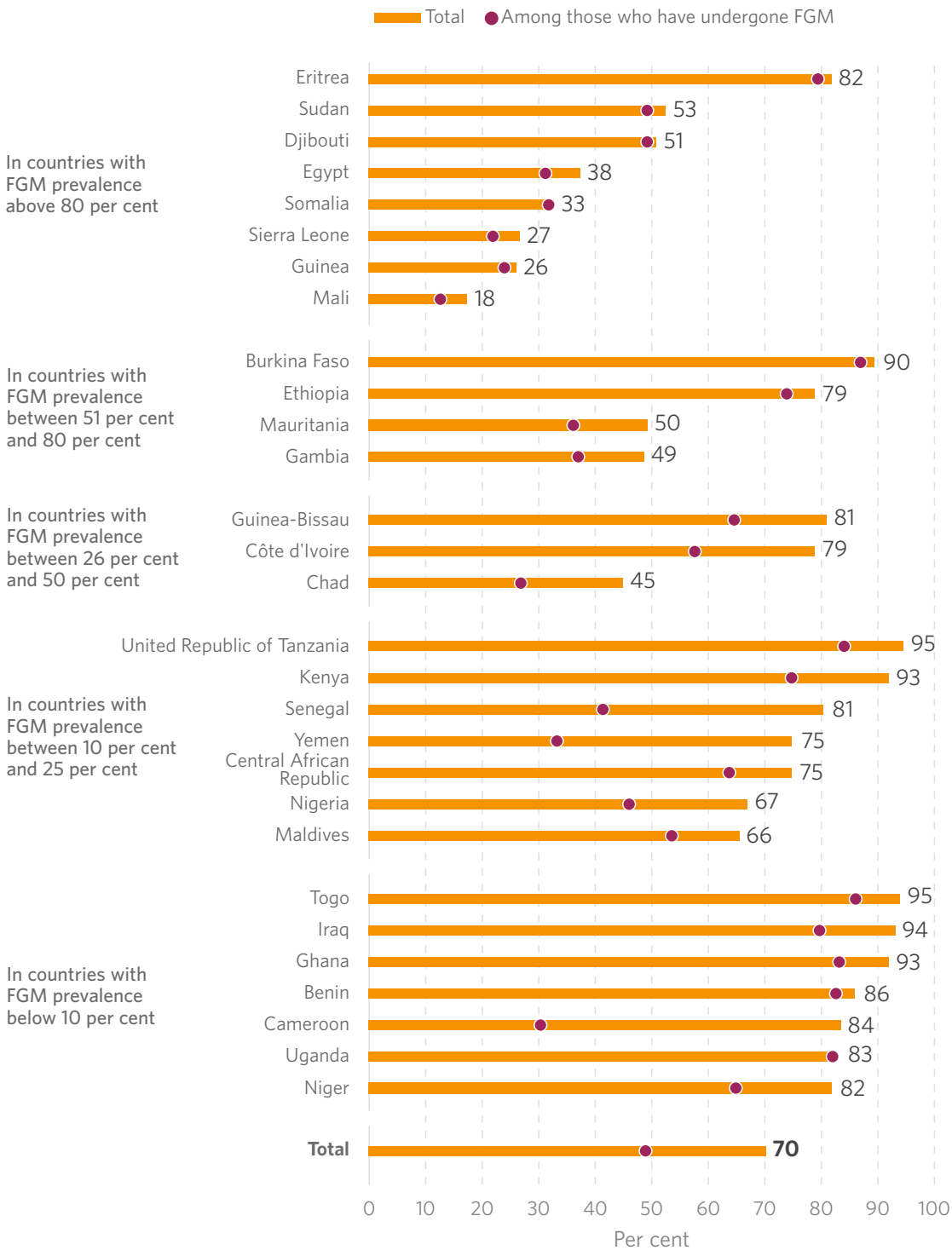
Girls' and women's attitudes vary widely across countries. In most countries where data are available, the majority of women and girls think the practice should end. In Egypt, the Gambia, Guinea, Mali and Sierra Leone, however, more than half the female population thinks the practice should continue.

Studies have shown that women who are aware of the physical risks associated with FGM—such as HIV infections, obstetric fistula and complications giving birth—are less likely to continue the practice (Ashimi and others, 2015).

Five in 10 women and girls who have undergone FGM think the practice should end (Figure 4.3). Adolescent girls are more likely than older women to oppose FGM (Figure 4.4). In 12 of the 19 countries with data on the attitudes of boys and men, more than 50 per cent of those surveyed oppose the continuation of the practice (Figure 4.5) (UNICEF, 2020).

FIGURE 4.3

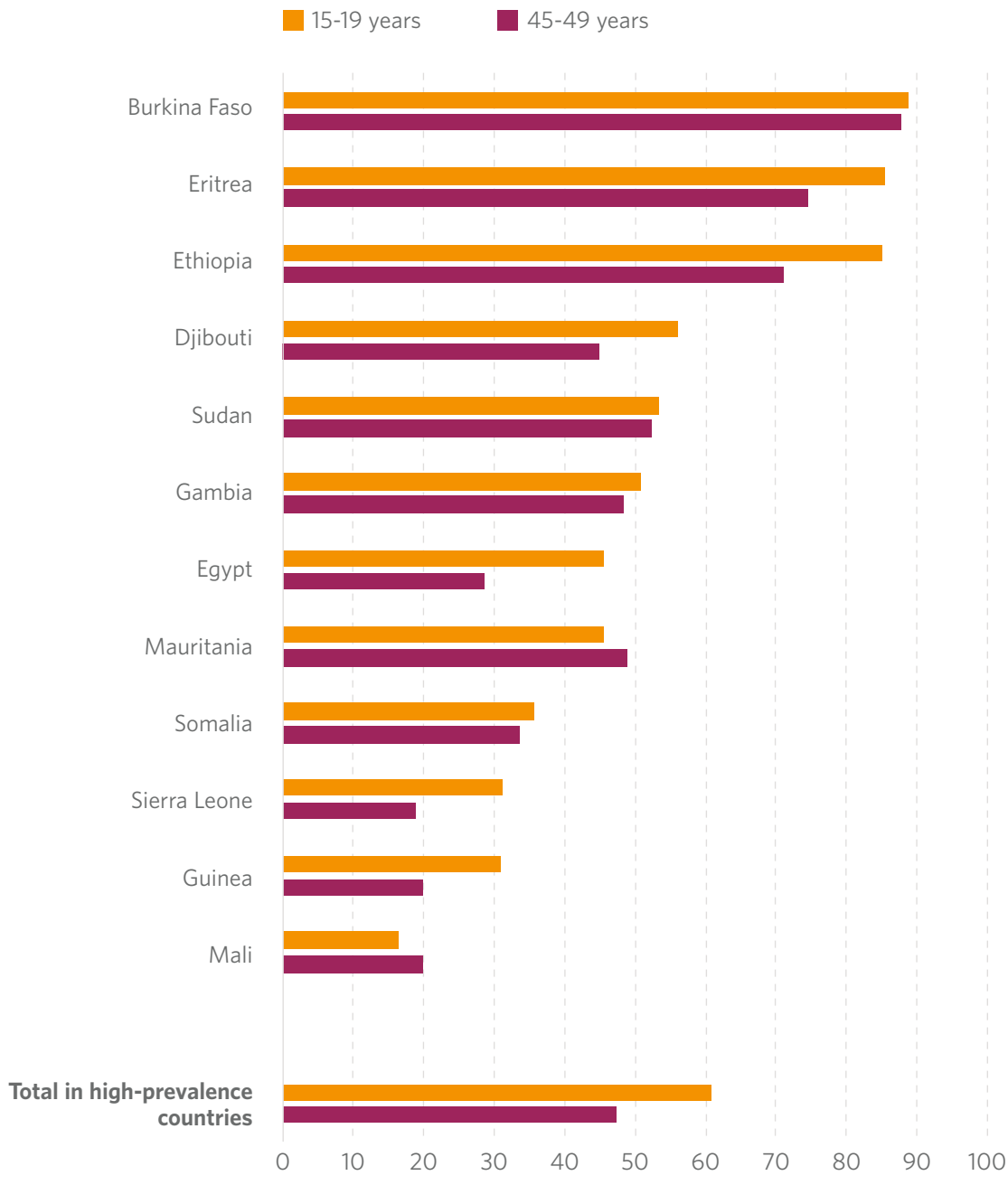
Percentage of girls and women aged 15 to 49 years who have heard of female genital mutilation (FGM) and think the practice should stop



Based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other nationally representative surveys. Notes: In Egypt and Somalia, attitudes towards FGM were calculated among all girls and women, since respondents were not first asked whether they had heard of the practice. Data for Liberia are not presented here since only girls and women who had undergone FGM were asked about their attitudes towards the practice. Data on attitudes towards FGM are not available for Indonesia.

FIGURE 4.4

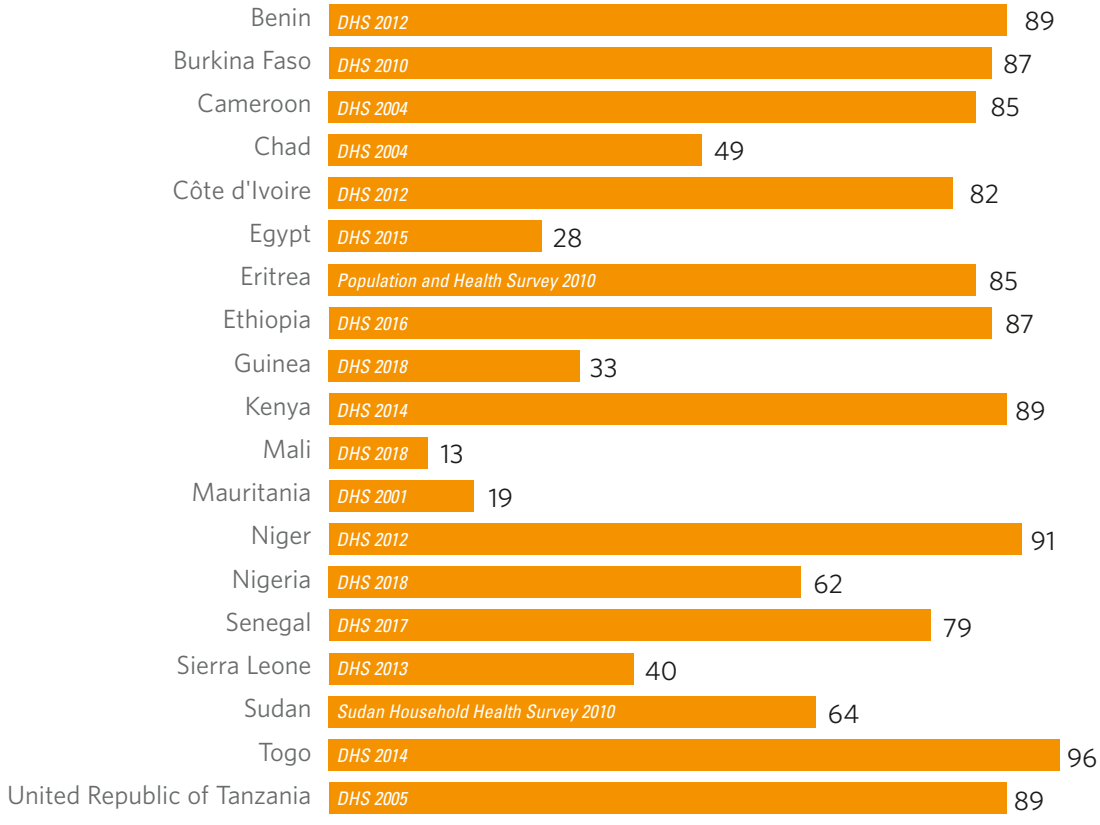
Percentage of adolescent girls aged 15 to 19 years and women aged 45 to 49 years who have heard of female genital mutilation (FGM) and think the practice should stop (in high-prevalence countries)*



* In high-prevalence countries, at least 50 per cent of girls and women have undergone FGM.
Based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other nationally representative surveys.

Adolescent girls are more likely than older women to **OPPOSE FGM.**

FIGURE 4.5 **Percentage of boys and men who have heard of female genital mutilation and think the practice should stop**



Based on Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other nationally representative surveys.

Current issues

Medicalization of FGM

Health-care providers are increasingly involved in performing "medicalized" FGM (UNFPA, 2018). An estimated 52 million women and girls have undergone FGM performed by doctors, nurses or midwives (UNICEF, 2020). In countries such as Egypt and Sudan, an estimated eight in 10 girls who undergo FGM have the procedure done in the offices of health professionals (as of 2014).

Some health-care providers agree to perform the procedure because they view medicalization as a way of reducing its harm, believing that the use of sterilized instruments in clean office environments reduces the risk of infection and complications, or that a doctor will offer less extreme options, such as piercing or cauterizing genitalia.

Although a medical professional may promise a "less extreme" procedure, there is no guarantee that the outcome will be any different than if the procedure is carried out by a traditional practitioner. There is evidence that what is often reported as a "nick" turns out to be a more severe form of FGM (Leye and others, 2019; Morison and others, 2001). A study in Sudan that involved medical examinations of women who claimed to have undergone "just a nick" found that approximately one third had actually undergone infibulation, where the vagina is partially stitched shut, and all had had their clitorises and labia minora removed (Elmusharaf and others, 2006).

In the face of medicalization, it is important to emphasize that FGM can never be "safe" and there is no medical justification for the practice. Even when the procedure is performed in a sterile environment by a health-care provider, there is the risk of health consequences immediately and later in life. Under any circumstances, FGM violates human rights. It also violates medical ethics (WHO, 2016).

Performing FGM in a doctor's office serves to normalize the practice, undermining efforts to eliminate it altogether. Like FGM carried out by traditional practitioners, medicalized FGM causes physical and psychological harm, perpetuates gender-based discrimination and violence against girls and women (Askew and others, 2016) and violates bodily integrity and dignity of the person (Nabaneh and Muula, 2019). FGM is also noted in the global North. The British Society for Paediatric and Adolescent Gynaecology reported that 266 labial reductions were performed on girls under the age of 14 between 2008 and 2012 (Barbara and others, 2015).

Crossing borders, circumventing bans

Cross-border FGM has emerged where girls and women and traditional practitioners cross into neighbouring countries to avoid prosecution under domestic laws prohibiting the practice (Sakeah and others, 2019; Twenty-Eight Too Many, 2018). Some modern-day borders separated ethnic groups that share a common history and traditions, including harmful practices.

Of 22 countries with legislation prohibiting FGM, only three have legislation that criminalizes cross-border FGM: Guinea Bissau, Kenya and Uganda (Twenty-Eight

Too Many, 2018). This gap in legal frameworks "fails to recognize the obligation of States to protect all children within their jurisdiction and does not take into consideration the mobile, transnational character of practising communities" (Twenty-Eight Too Many, 2018). With insufficient collaboration among governments, girls living in practising communities along borders with countries with weaker or no legislation are at increased risk (Twenty-Eight Too Many, 2018).

Paths towards a world free from FGM

International agreements

In unanimously endorsing the United Nations 2030 Agenda for Sustainable Development, 193 Member States committed to ending FGM by 2030. Target 5.3 of the Sustainable Development Goals is to "eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation".

Additionally, many human rights treaties and conventions require States Parties to take all measures, including enacting laws, to stop FGM (Table 4.2). After Burkina Faso passed a law in 1996, for example, the incidence of FGM fell by an estimated 30 per cent (Crisman and others, 2016). The decrease could not, however, be attributed solely to the law because other interventions had been introduced at the same time. In Ethiopia, a study found that parallel interventions involving legislation, community and religious dialogues, and community education sessions about the harmful effects contributed to some decrease in FGM (UNICEF, 2012).

TABLE 4.2 **Countries with laws, executive orders or resolutions related to female genital mutilation**

Australia (6 out of 8 states, 1994–2006)
Austria (2002)
Belgium (2000)
Benin (2003)
Burkina Faso (1996)
Canada (1997)
Central African Republic (1996, 2006)
Chad (2003)
Colombia (2009 by indigenous authorities)
Côte d'Ivoire (1998)
Cyprus (2003)
Denmark (2003)
Djibouti (1994, 2009)
Egypt (2008)
Eritrea (2007)
Ethiopia (2004)
France (1979)
The Gambia (2015)
Ghana (1994, 2007)
Guinea (1965, 2000)
Guinea Bissau (2011)
Ireland (2012)
Italy (2005)
Liberia (2018)
Luxembourg (2008)
Kenya (2001, 2011)
Mauritania (2005)
New Zealand (1995)
Niger (2003)
Nigeria (2015)
Norway (1995)
Portugal (2007)
Senegal (1999)
South Africa (2000)
Spain (2003)
Sudan (South Kordofan 2008, Gedaref 2009)
Sweden (1982, 1998)
Switzerland (2005, 2012)
Tanzania (1998)
Togo (1998)
Uganda (2010)
United Kingdom (1985)
United States (1996)
Zambia (2005, 2011)

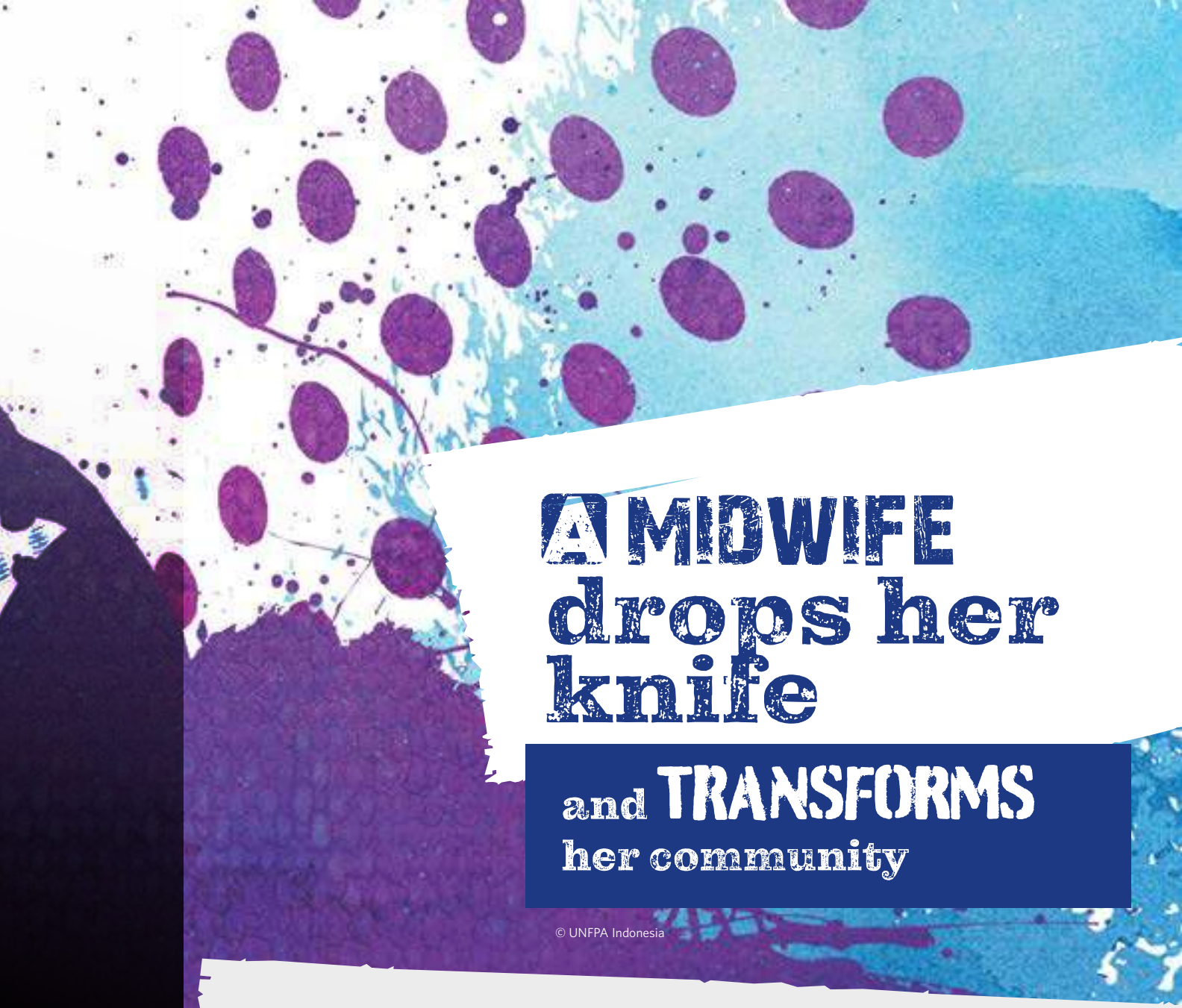
Changing norms

Ending FGM requires changes in social norms—what communities believe, how they act and how they expect the members of their community to act (Johansen and others, 2013; Mackie, 2009). Gender norms, a subset of social norms, shape how men and women see themselves, their social and intimate relationships, their sexuality and the allocation of power and resources (Alexander-Scott and Violence Against Women, 2016). Both social and gender norms must change before a community decides to abandon a harmful practice.

Women may uphold the norms that harm them because the social costs of doing otherwise would be unacceptably high. Even though a social norm may be harmful, it may give women status in their communities, and some women may tolerate loss of control and agency in exchange for economic support (Sen and Ostlin, 2008).

The social norms approach to elimination has been key to the success of initiatives such as the Community Empowerment Programme, launched in 1988 in Senegal and implemented by Tostan, a non-governmental organization (Diop and others, 2004). The programme supports changes in social norms by stimulating personal and collective reflection and critical thinking through community dialogues, education sessions, and "organized diffusion" (UNICEF, 2010).

Organized diffusion involves spreading and reinforcing information about the benefits of abandoning FGM within and between communities using peer-to-peer



A MIDWIFE drops her knife and TRANSFORMS her community

© UNFPA Indonesia

When Suci Maesaroh went to midwifery school in Indonesia, female genital mutilation, or FGM, was not covered in the curriculum. But as soon as she began to practise, it became clear that performing FGM was an expectation of her profession.

"I learned how to do female circumcision and directly practised it in the community," Maesaroh explains matter-of-factly. "During my work in the clinic, for two years, I performed FGM, or female circumcision, on my patients because it was part of the service package I delivered."

She remembers it vividly: "Every time a family asked me to do so, I circumcised the baby with a clamp on a sensitive part of a newborn baby. I pinned it until the baby cried, otherwise I cleaned it before I just pinned it. Then the baby cried."

Although FGM is most widely associated with parts of Africa, it is a global practice. It takes place in communities around the world, across ethnicities and religions. In Indonesia, the practice is known to take place but it is not well studied.

Maesaroh was not aware of FGM until she began to perform it as a midwife. "Initially, I did not know whether female circumcision was dangerous or not, because it is just performed to follow religious and cultural practices," she recounts.

Two years into her career, she attended a workshop on FGM, supported by UNFPA, which covered the physical and psychological consequences of the practice—from pain and loss of sensation to risk of haemorrhage and death. "The next day I promised myself that I would not perform FGM anymore. And I started to inform my patients, to educate my patients on the health facts about FGM."

Maesaroh also took her stance public, posting about it on social media and speaking about it within the community.

She discovered that many parents were not strongly attached to the practice. "Most of my patients did not know what female circumcision is, or why it is practised.

They just followed what, according to them, were religious or cultural beliefs. After informing them patiently, some of them finally also refused to have FGM performed on their daughters."

But Maesaroh also faced strenuous opposition—most surprisingly from her own family and colleagues. "Even my mother told me FGM or female circumcision was the family tradition," she says.

> "The next day I promised myself that I would **NOT** perform **FGM** anymore. And I started to inform my patients, to **EDUCATE MY PATIENTS** on the health facts about FGM."

"Lots of my friends opposed me," she adds, noting that some midwives argued in favour of FGM because it offers a source of income. "I emphasized that we should not be looking for a source of profit if it can harm the patient."

Maesaroh quit working at the clinic where FGM was considered a routine procedure. She now provides services directly to pregnant and post-partum women. During house calls, she tells families that FGM is a dangerous practice with no religious basis and no health benefits.

She says she is haunted by the years she spent performing FGM. "I sometimes feel sorry because I did not think that, for example, clamping sensitive parts or the clitoral part would feel very painful," she says.

But she has hope that things will change. Over time, her family and many of her friends have come around to her perspective. "Finally, my parents now also support me in the movement to not do any more female circumcision."

She has been happy to partner with the Indonesian Midwives Association, a powerful advocate for ending FGM. Maesaroh says health workers must lead the way, because they have the authority and credibility to convince parents to abandon the practice.

"I am quite sure if we explained to our patients, they will not ask or will not want their girls to be circumcised," she says.

communication as well as mass and social media. This model creates a social movement that engages communities and those who are influential in them, such as religious leaders. Once enough community members are engaged, a "tipping point" is reached, leading to the adoption of a new social norm to keep girls and women intact (UNICEF, 2010). The collective shift is marked by a community pledge: a public declaration of FGM abandonment.

An important element of the Community Empowerment Programme model is a human rights focus, which shapes community discussions about practices that violate the rights of girls and women and helps shift social and gender norms away from FGM (Costello and others, 2015; UNICEF, 2010).

To shift social norms towards FGM abandonment, change must come from within and be community-led (Cislaghi, 2019; Spindler, 2015; Johansen and others, 2013; Berg and Denison, 2012). Participatory approaches are more effective than ones that aim to educate or lecture communities (Diop and Askew, 2009). An evaluation of a UNFPA–UNICEF Joint Programme on Eliminating Female Genital Mutilation found that community-led approaches have led to shifts from "general public approval of FGM" to "general public condemnation of FGM" (UNFPA and UNICEF, 2013).

Traditional and religious leaders

Traditional and religious leaders are often key decision makers and the custodians of tradition, culture and rights and can be instrumental in persuading community members to adopt new norms, such as the abandonment of

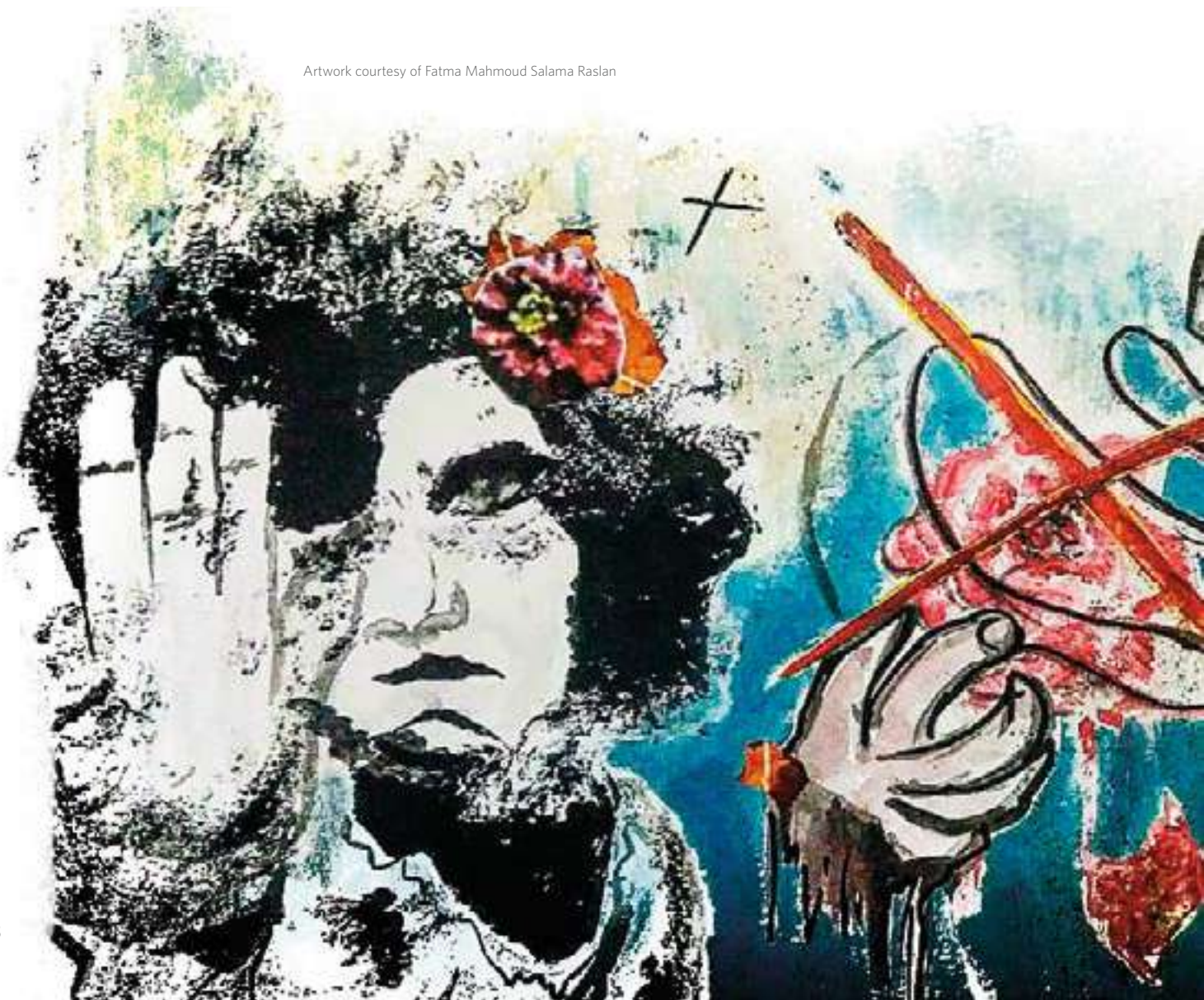
FGM (Palitza, 2014; UNICEF, 2010). Where FGM may be seen as a religious requirement, religious leaders are in a position to make public statements delinking FGM and religion and therefore influence families' decisions about whether to subject girls to FGM, as Muslim and Christian leaders have done in Egypt, Eritrea, Ethiopia, Mali, Mauritania and Somalia (UNICEF, 2010; Hadi, 1998).

Holistic and multisectoral approaches

Because harmful practices are held in place by a mix of societal forces, addressing them requires holistic multisectoral approaches that engage with households, community leaders, institutions and policymakers (Heise and Manji, 2016; Feldmans-Jacobs, 2013).

The UNFPA–UNICEF Joint Programme on Eliminating Female Genital Mutilation, for example, has a holistic design that works at the global, regional, national and grassroots levels and across sectors ranging from education and health to social protection and justice. As a result, the programme has developed synergies that facilitate the engagement of diverse stakeholders, including faith-based organizations, teachers, youth peer groups, law enforcement, health-care providers and parents in support of structural change (UNFPA and UNICEF, 2013).

Artwork courtesy of Fatma Mahmoud Salama Raslan



Social norms marketing

Social norms marketing integrates marketing tools and other techniques and channels specifically to change social norms and the behaviours driven by them. The use of mass media and marketing approaches is an efficient way of reaching large numbers of people at relatively low cost, and is also particularly well-suited to changing attitudes towards harmful behaviours and norms at scale (Alexander-Scott and others, 2016).

One example is Sudan's Saleema campaign, started in 2008, which promotes a positive view that girls who remain intact are respectable

(UNFPA and UNICEF, 2013). The campaign communicates new positive terminology to describe the natural bodies of girls and women through television, radio and print media (Rahman and others, 2018).

Sustaining community commitments

Community-based systems for following up on public declarations about abandoning FGM can play an important role in protecting girls from the practice. In Senegal, for example, communities that have passed community declarations against FGM have set up committees that track cases of FGM or follow up with families that intend to subject a girl to the practice. These committees raise awareness around the importance of abandoning FGM and actively persuade community members to leave their daughters intact (UNFPA and UNICEF, 2013).

The role of girls' clubs

Clubs for adolescent girls both in and out of school can provide opportunities to learn about FGM and other matters that affect their lives and to expand their social networks. Girls' clubs can also help shift gender norms by increasing girls' self-confidence, encouraging them to express their opinions, and providing access to role models who may also serve as mentors who support girls through the transition from adolescence to adulthood (Marcus and others, 2017; Brady and others, 2007).

A role for men

Many men would like to see FGM end—more than half of men and boys surveyed in countries with data—but are afraid to express their views because of extreme social pressure. Communities can promote change from within by creating space for dialogue among men and women about

the harm it causes and the benefits to be realized from abandoning the practice (Mitike and Deressa, 2009). Men's clubs can facilitate health literacy that enables them to make informed and healthy choices for their families and themselves (Varol and others, 2015). Clubs can raise awareness and provide reproductive health education for men (Onyango and others, 2010; Spadacini and Nichols, 1998).

An end to FGM is in sight

The end of FGM by 2030 is within reach, but accelerated action is needed or the goal will not be met and millions more girls will be harmed, in violation of their rights. While progress has been made, it has not been fast enough to eliminate this harmful practice within the next 10 years. Even in countries where FGM has become less prevalent, progress would need to be at least 10 times faster to meet the global target of full elimination by 2030 (UNICEF, 2020).

Programmes should empower women and girls who oppose FGM to make their voices heard. Programmes that empower communities and change social norms have resulted in the long-term abandonment of FGM. A recent analysis found that if successful community-driven efforts were scaled up and fully funded, this harmful practice would end in 31 countries by 2030 (UNFPA, 2020). The analysis estimated that $2.4 billion would be needed over 10 years to achieve this goal. Of that total, $2.1 billion is needed for FGM-prevention programmes, $225 million for protection programmes and $130 million for care and treatment.

Governments, civil society, social movements, and activists, as well as communities themselves, know what works.

Survivors and advocates call for RETHINKING female genital mutilation—

and women's sexuality

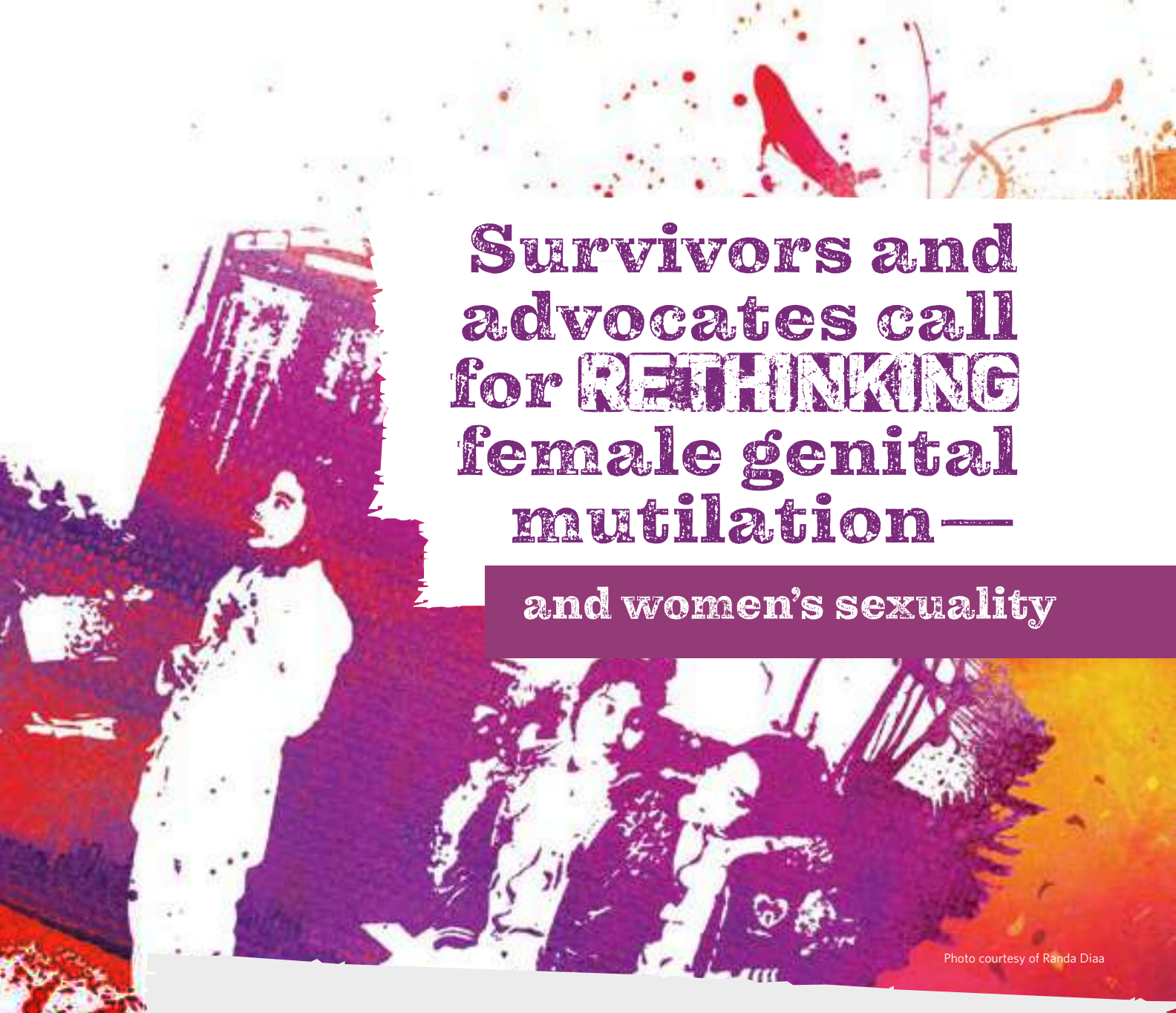


Photo courtesy of Randa Diaa

Randa Diaa remembers wearing a new red dress, the music that played and the henna decorating her hand.

"I was very happy," she recalls, "they made me feel like a bride."

But then she was taken to the doctor's office. She remembers her "heart sank" as she realized she was there for a procedure: female genital mutilation, or FGM. She was 7 years old.

In her community in the Upper Egyptian governorate of Aswan, these were the rituals associated with cutting girls. "It's a celebration," Diaa says, "we dress in red, we apply henna and we bathe in the Nile."

> “We always hear that playing sports, for example, is good for you. **We should also frame sexuality as something healthy,** as something normal that can create a **healthy marriage and make people happy.**”

The day did not go as planned. There were complications with the procedure. She spent three days unconscious in an intensive care unit. She remembers waking to see her mother crying and praying at her bedside.

When she finally went home, her father received a constant stream of guests congratulating him for his daughter’s “coming of age”.

“I remember my father being teary-eyed the entire time,” Diaa says, “and when people asked him what’s wrong, he told them that the doctor had cut an artery.”

A few days later, against the doctor’s orders, Diaa went outside to play with her friends. “We were just passing a ball to each other, but one boy bumped into me and I fell and started bleeding,” she recalls. The fall reopened Diaa’s wound, sending her back to the hospital.

FGM is a widespread violation of girls’ and women’s rights in Egypt. A staggering 92 per cent of ever-married women, aged 15 to 49, have undergone FGM, according to the country’s 2014 Demographic and Health Survey.

The vast majority of cases—82 per cent—are performed by medical professionals, giving the appearance of legitimacy to a practice with no medical benefits and serious lifelong consequences.

Diaa says that her experience opened up this conversation in her family. "We're always talking about it. FGM remains a recurrent topic of discussion in my household." She and her siblings grew up to have daughters of their own; none of the girls has been subjected to FGM.

Today, Diaa is 40 and a strong advocate against FGM. She has founded her own non-governmental organization dedicated to helping her community abandon the practice. She visits community members to speak about the harms caused by FGM, and has even published a book of short stories inspired by her own experience and those of other survivors she's met.

She faces ardent opposition, especially from older women such as the grandmothers and mothers-in-law of the people she visits. "I am constantly being attacked, especially by mothers-in-law," she says. "They call me an infidel, and one woman even kicked me out of her house once."

One reason the practice remains so persistent in Egypt is that early advocacy efforts focused largely on the physical harms of FGM, rather than addressing the root cause—gender inequality—explains Dr. Hania Sholkamy, an anthropologist at the American University in Cairo's Social Research Center. She says the emphasis on physical harm led Egypt "down a dark path" towards medicalization.

Instead, people should understand that the practice arises from religious misinterpretations and cultural beliefs that are pretexts "to mask what is at the core, which is controlling women's sexuality," she says, adding that fear over women's sexuality comes from the deep belief that women should not be dominant.

"There is also a belief that a woman's sexuality is beyond reason, so controlling it means enabling her to stay celibate until marriage, or enabling her to deal with delayed marriage, or infrequent sexual intercourse," she explains.

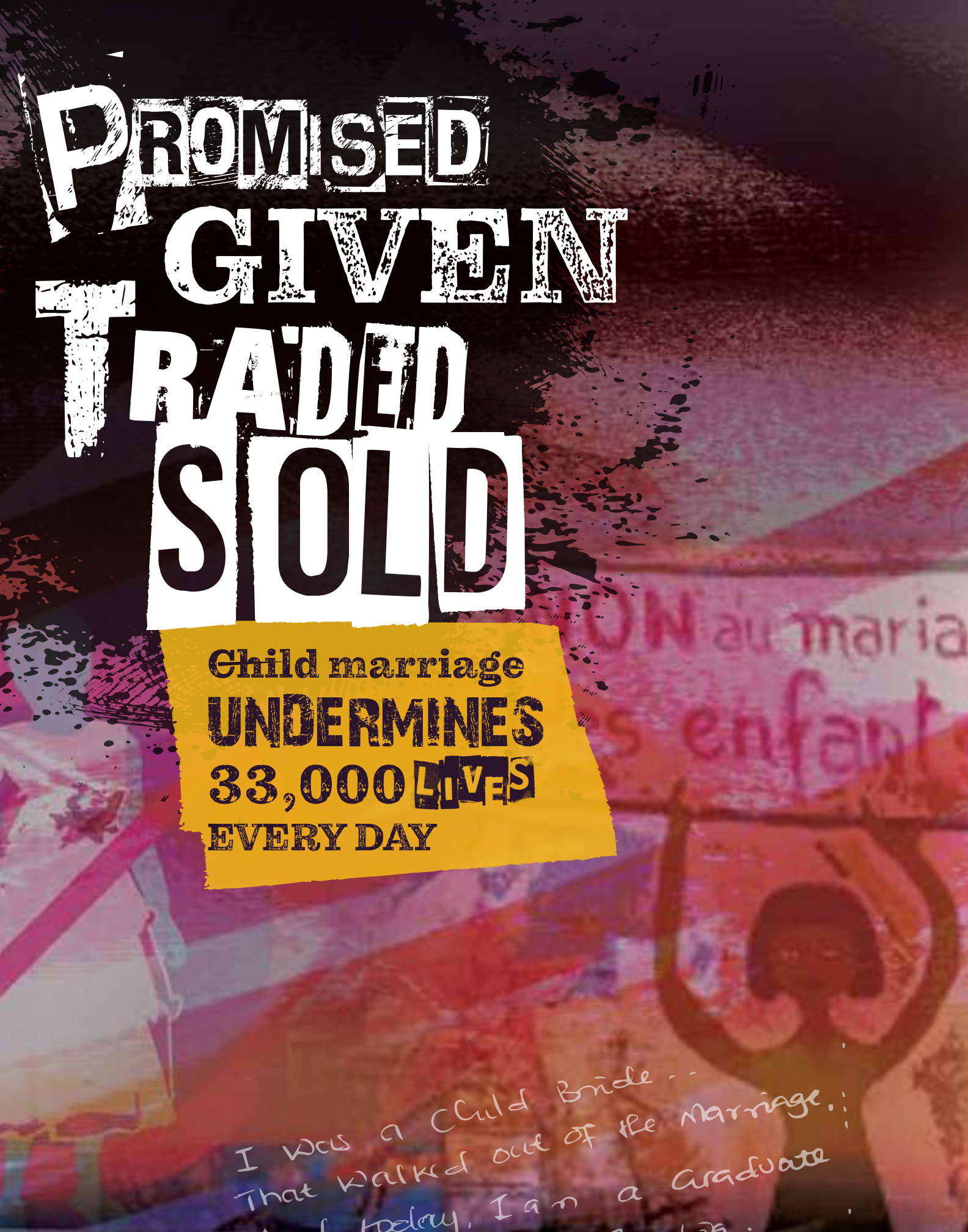
Rather than framing FGM as a health risk, Sholkamy believes that sexuality should be reframed.

"We always hear that playing sports, for example, is good for you. We should also frame sexuality as something healthy, as something normal that can create a healthy marriage and make people happy," she says.

Sholkamy believes that the messaging should focus on "healthy sexuality and healthy gender relations".

"We need to drown out messaging of medicalization and embrace the idea of positive, healthy sexuality," she explains.

"This can enable a change around FGM."


PROMISED
GIVEN
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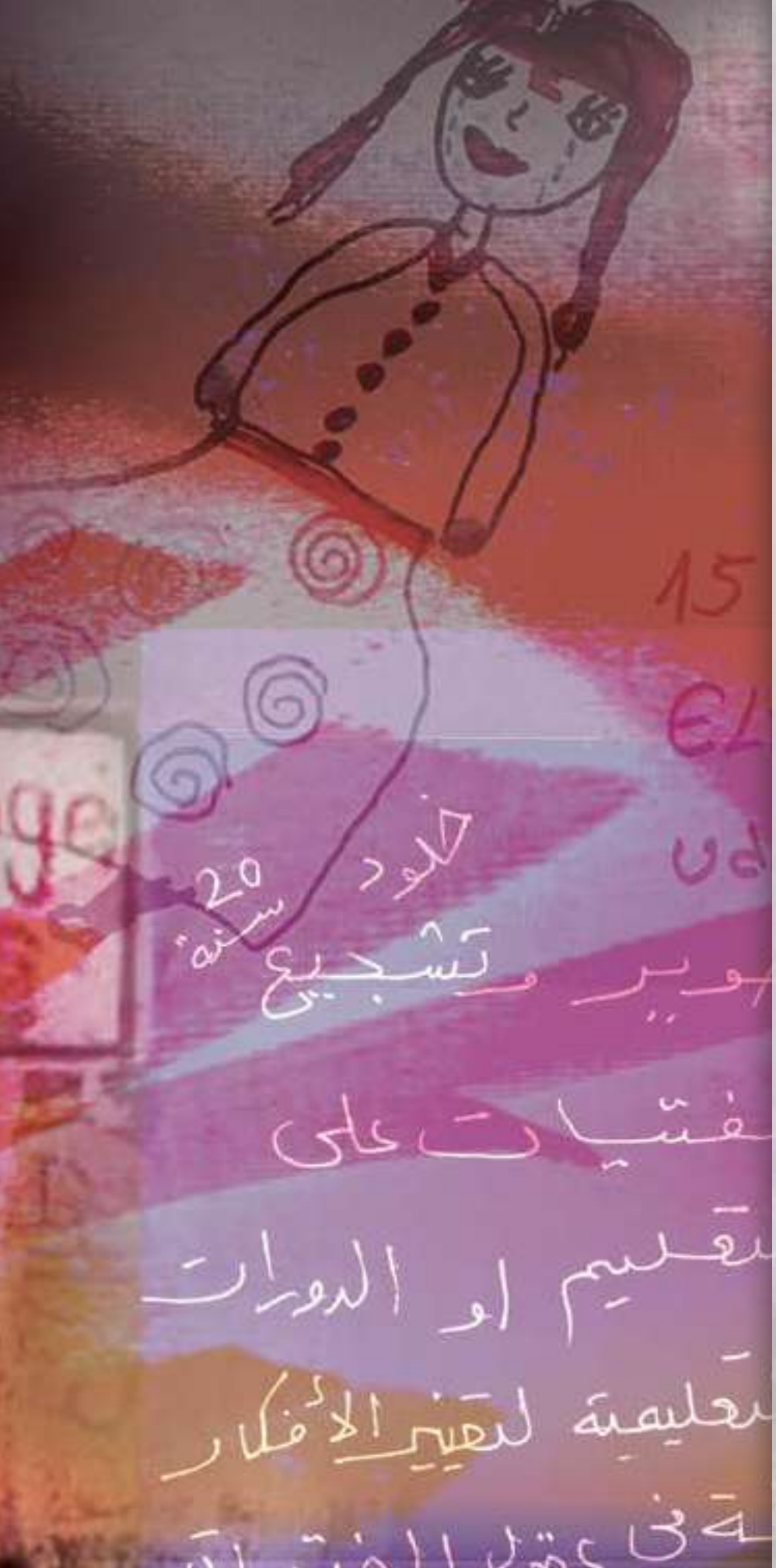
Child marriage
UNDERMINES
33,000 LIVES
EVERY DAY
I was a Child Bride..
That Walked out of the Marriage..!
Today, I am a Graduate



When a GIRL is married, her rights are VIOLATED.

Her schooling ends. Childbearing begins. Opportunities evaporate. Doors to the future slam shut.

Sometimes she is given away. Sometimes she is traded for something of value. Sometimes she is a burden offloaded onto someone else. Sometimes she is handed over to someone deemed to be capable of ensuring her security. But rarely, if ever, is she the one who makes the decision.

"I was only 12 years old when I got married to my 25-year-old cousin. My mother entered my room while I was sitting on the floor, colouring in my princess colouring book. She sat on the bed and told me 'Najma, tomorrow you will get married.'"

Child marriages are almost universally banned, yet they happen 33,000 times a day, every day, all around the world. An estimated 650 million girls and women alive today were married as children, and by 2030, another 150 million girls under the age of 18 will be married.

Of the harmful practices UNFPA is committed to ending, child marriage is the most prevalent, undermining the rights and futures of 12 million girls each year. Zero child marriages by 2030 is a goal set by UNFPA and a priority in the United Nations 2030 Agenda for Sustainable Development and its accompanying Sustainable Development Goals.

Although the cost to individual girls' rights, choices and opportunities is incalculable, attempts to measure the loss of human potential place a high economic price on child marriage. The World Bank found that in just 12 countries where child marriage is prevalent, the loss of human capital would amount to $63 billion between 2017 and 2030, much more than these countries received in official development assistance (Wodon and others, 2018). Eliminating child marriage would have enormous benefits for not only the empowerment of girls, but also for their health, education and well-being, as well as for communities and nations.

Denied the right to decide whether, when and whom to marry

Child marriage is a fundamental violation of human rights that robs girls of their education, health and long-term prospects. Defined as a union where either party is below the age of 18, it exists throughout the world but is most common in poor and rural areas of some developing countries. Child marriage applies to both boys and girls, but the greatest ill effects fall upon girls, because of the greater numbers affected and the particular harm that girls suffer from marrying too young. When boys are married young, it accelerates their transition into adult roles and brings the pressure of having to provide for their newly formed families.

Child marriage is a harmful practice, commonly imposed on children by family members, community members or society at large,

regardless of whether the victim provides, or is able to provide, full, free and informed consent.

Child marriage is sometimes described by terminology such as "forced" or "early" marriage. In many societies, marriage at the age of 18 and into the early 20s would be considered "early" marriage, but this does not necessarily come with the specific violations or harms caused by marriage below the age of 18. Forced marriage can happen at any age but not all marriages below the age of 18 are forced—in some parts of the world, consensual marriages or unions where one or both partners are minors are not uncommon. However, many of these "self-initiated" marriages and unions are driven by societal prohibition of sexual activity among unmarried adolescents, particularly girls, and by adolescents' desire for independence and mobility; they may also be viewed as a way to escape family poverty and violence (Greene and others, 2018).

Child marriage exists in every region

Child marriage is a major societal challenge being faced by countries in several parts of the world, but the issue is most acute in South Asia, sub-Saharan Africa and parts of Latin America and the Caribbean. It exists in many different contexts, in both developing and developed countries, but its prevalence both historically and today varies widely. (Prevalence is the percentage of women aged 20 to 24 who were married or in an informal union before 18.) In Sweden, a country with extensive historical records, for example, only 9.3 per cent of girls were married by age 19 in the period 1646 to 1750, and this had decreased to 7.2 per cent by 1860 (Lundh, 2003). In the United States, recent figures from New Jersey, where, until 2019, couples could marry as young as 16 with parental consent, show that some 3,500 minors were married between 1995 and 2012—most were girls aged 16 and 17 married to an adult over 18 (Reiss, 2015).

Globally the prevalence of child/early marriage is around 21 per cent (UNICEF, 2019a). The prevalence of child marriage was almost 60 per cent in South Asia in 1990 (Wodon and others 2018a). Today, the highest prevalence is in West and Central Africa at 40 per cent, followed by East and Southern Africa at 34 per cent (UNICEF, 2019a). In Latin America and the Caribbean, one in four girls are married or in informal unions before the age of 18; in some parts of the region, the figure is more than one in three (UNICEF, 2019b).

Although advances in India have contributed to a 50 per cent decline in child marriage in South Asia—to 30 per cent in 2018 (UNICEF, 2019c)—the region still accounts for the largest number of child marriages each year, estimated at 4.1 million in 2017, while sub-Saharan Africa accounts for 3.4 million (Wodon and others, 2018a). Other parts of the developing world have considerably lower prevalences, at 18 per cent in the Middle East and North Africa and 7 per cent in East Asia and the Pacific (UNICEF, 2019a). In Bangladesh, the Dominican Republic, Nicaragua and 17 countries in sub-Saharan Africa, at least 10 per cent of young women were married or in unions before the age of 15 (UNICEF, 2019a).

The prevalence of child marriage is decreasing globally, falling from about 25 per cent in 2006 to 21 per cent in 2018, with several countries, notably India, seeing significant reductions (UNICEF, 2018). An analysis of trends in 56 countries for which World Bank data were available for the period 1990 to 2018 showed three identifiable trends: in one third of countries, prevalence fell by 0.6 percentage points annually for a linear or steady decline; in one third abrupt decreases (13 percentage points on average) were followed by periods of little or no change; and in one third there was no decrease or an increase of up to 0.5 percentage points (Table 5.1). If the Sustainable Development Goal of eliminating child marriage is to be achieved by 2030, the most concerted efforts need to be made in South Asia, sub-Saharan Africa and Latin America and the Caribbean.

Child marriage cuts across countries, cultures, religions and ethnicities. It happens because girls are usually less valued than boys, and because poverty, insecurity and limited access to quality education and work opportunities mean that child marriage is often seen as the best option for girls (Girls Not Brides, 2019) or as a way for parents to mitigate the household's difficult economic circumstances. In all regions, child marriage is closely tied to low levels of education, poverty and rural residence.

Drivers and determinants

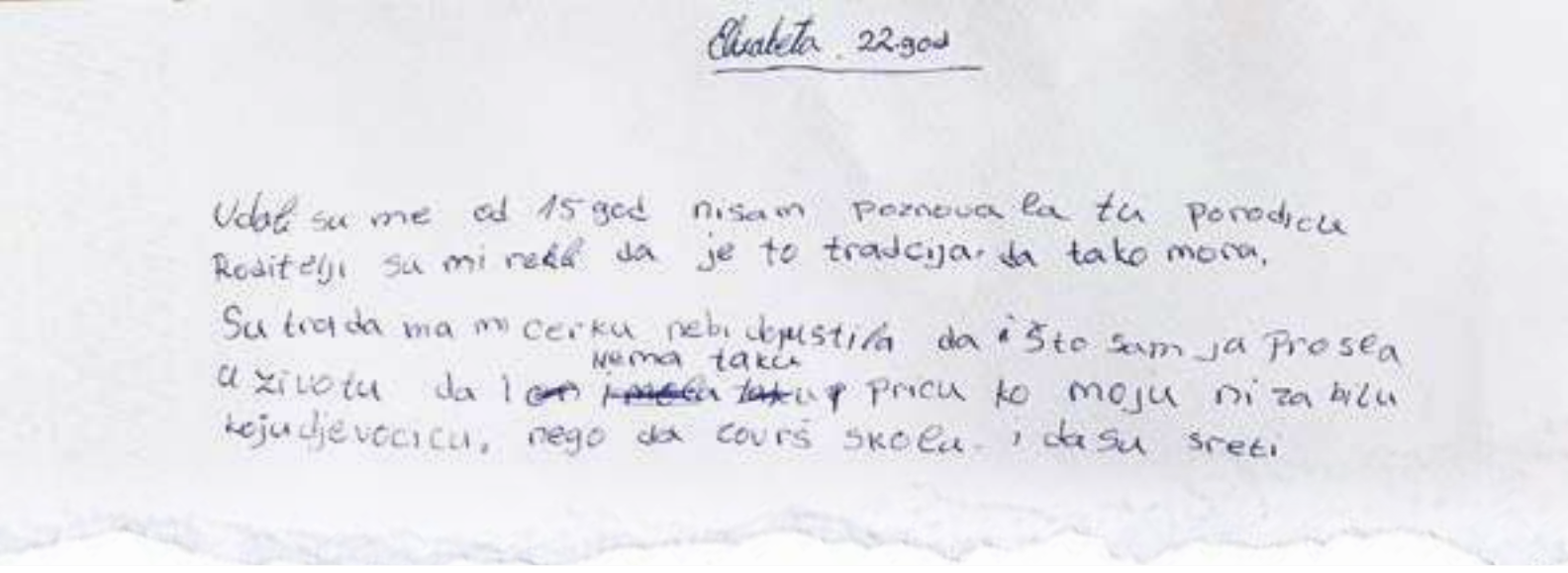
Discriminatory gender and social norms

Gender discrimination, reflected in patriarchal institutions and sociocultural norms, consigns girls and women to their role as unpaid domestic labour, childbearers and mothers. This discrimination extends to placing a high value on a girl's virginity and fears about female sexuality, which contribute to girls being forced into early marriages while they are still "intact" (Khanna and others, 2013). Some parents believe that early marriage is a safeguard against premarital sex and

TABLE 5.1 **Nearly two thirds of countries show a decline in child marriage, 1990 to 2018, number by region**

	Number of countries with a steady decline	Number of countries with an abrupt decrease	Number of countries with no change or an increase	Total
Sub-Saharan Africa	7	9	12	28
South Asia	2	3	0	5
Latin America	3	1	6	10
Other	5	4	4	13
Total	**17**	**17**	**22**	**56**
Girls married as of 2018	**16.2 million**	**41.6 million**	**13.1 million**	**70.9 million**

Note: Table covers 56 countries with four or more data points.
Source: World Development Indicators 2019.



I was married at 15, I didn't know that family. My parents told me it is a tradition and that it is the way it has to be. Tomorrow, if I have a daughter, I wouldn't let her have a life like mine. I went through this so she will not have a story like mine. Or any girl. They have to finish school and be happy.

Elizabeta, 22 years old, Bosnia and Herzegovina

protection from sexual harassment (UNFPA, 2012a). Perpetuating the cycle, younger mothers may have little power to decide whether and when their daughters will be married, leaving their husband and other family and community members with the power to take life-altering decisions on behalf of girls (UNICEF and UNFPA, 2018). Other social factors include a sense of tradition and social obligation, risk of pregnancy out of wedlock, avoiding criticism whereby older unmarried girls may be considered impure, and the belief in some communities that religion encourages marriage as of puberty (Karam, 2015).

Social norms underpin all systems of marriage. The norms that underpin child marriage in a particular society are based on such beliefs as expected paths into adulthood, views on sexuality among boys and girls, views on gender roles, the importance of respect for age hierarchies, interpretations of religious beliefs, underlying gender inequality and gender-based definitions of economic roles. Many of these are patriarchal norms that relegate girls and women to an inferior and subservient status, denying them agency to make their own decisions (Greene and others, 2018).

Girls have neither voice nor choice

In deeply hierarchical societies where men have power over women, and older people have power over younger ones, girls face the double disadvantage of being both female and young. Child marriage exists in situations in which adolescents are not listened to, and girls are not consulted on the decisions that affect their lives (Girls Not Brides, n.d.). This is particularly true for girls under the age of 15 and those with less education. When girls have a choice, they usually decide to marry later. For this reason, many programmes designed to end child marriage choose to empower girls, including through education. Whether or when a girl is married is linked to the extent to which she is empowered to know her rights,

make her own decisions in life and chart her own future.

Level of education

Girls with only a primary education are twice as likely to be married or in a union than those with a secondary or higher education. Girls with no education are three times more likely to be married or in a union before age 18 than those with a secondary or higher education (UNFPA, 2012a). In India, 51 per cent of young women with no education and 47 per cent of those with only a primary education had married by age 18 (UNICEF, 2019c). Meanwhile, 29 per cent of young women with a secondary education and 4 per cent with post-secondary education were married before 18. While the prevalence of marriage is far lower among boys, a similar education gradient holds: the percentage of men aged 20 to 49 who married by age 18 appears higher among those with no education or only primary schooling compared with those with secondary education or higher (Misunas and others, 2019).

An analysis of child marriage data included in the World Bank's World Development Indicators shows that among girls married by age 18 in India, 46 per cent were also in the lowest income bracket. Similarly, in Niger, the third poorest country in the world, where only 17 per cent of girls complete lower secondary school and 84 per cent of the population is rural, some 76 per cent of girls were first married by age 18.

Many of the factors that impact on the prevalence of child marriage have an economic foundation. Child marriage is

Fraidy Reiss [center], a forced marriage survivor, founded and leads Unchained at Last, dedicated to ending forced and child marriage in the United States. Photo by Susan Landmann

Groomed, abused, unbroken

Child marriage survivors demand change

"It was a bad experience for me in my life," says Sherry Johnson, referring to her marriage at age 11 in the US state of Florida.

Johnson describes the horrors she experienced. She was raped and impregnated by a trusted member of the community. After giving birth, she was married off by her parents to protect the rapist from investigation.

Although it happened 49 years ago, Johnson says she experiences the fallout from it every day. "It has caused me to still experience rough times in my life because the abuse at that age, it stagnates your growth."

These days, she works from 7 in the morning until 8 in the evening. "I was never able to really go to college and get degrees. I work hard for every penny right now. I work three jobs just to be able to survive, keep food on the table, a roof over my head."

Her experience was decades ago, but the phenomenon of child marriage persists today in the United States. Because the minimum age of marriage is set by each state, not by the national government, wide variations exist in the legality of underage marriages. Only four of the country's 50 states outlaw child marriage without exception, according to the Tahirih Justice

Center, a non-governmental organization that advocates on the issue. Most states allow exceptions for pregnancy, parental consent or emancipated minors. In 10 states, there are no statutory age minimums, according to Tahirih.

Between 2000 and 2015, more than 200,000 children under age 18 were married in the United States, according to marriage licence data analysed by the news organization Frontline. Donna Pollard was one of those girls. With permission from her mother, Pollard was allowed to marry at age 16. Her husband was a 30-year-old man who worked in the behavioural health facility in Indiana where her mother had sent her for treatment. She says he was abusive throughout their marriage.

Parental consent also led to Sara Tasneem getting married—at first informally, in a spiritual union at age 15, then legally at age 16. Tasneem had no choice in the matter. "We were raised with very strict gender roles," she says, speaking from her home in California. When boys began to express an interest in her, her father rushed to marry her off. "I was told… that I was going to get married because sex outside of marriage was forbidden… I was basically introduced to somebody in the morning, and I was forced to marry him that night." Her husband was 28 years old. "It was a very controlling and abusive relationship," she says. "I got pregnant right away, and we were legally married in Reno, Nevada, where it only required permission signed by my dad."

All three women eventually escaped their marriages, and all three have gone on to become powerful voices in the movement to end child marriage in the United States.

"I advocated to change the [law] in the states of Florida, Georgia and Louisiana, which we have accomplished, and I'm grateful for that," Johnson recalls.

Tasneem and Pollard have also testified in support of legislative changes to increase the age of marriage to 18. Between them, they've addressed lawmakers in California, Nevada, Kentucky, Tennessee and elsewhere. In response, many legislatures have increased the age minimum for marriage to 17 or required judges to approve the marriage of minors.

"I do think that we're making progress," Pollard says. "In just a few years, we have seen multiple states at least modify their laws to increase the age and put [in place] judicial approval criteria instead of blind parental consent."

"In just a few years, we have seen multiple states at least modify their laws to **increase the age** and put [in place] judicial approval criteria instead of blind parental consent."

For child brides, the barriers to leaving an abusive relationship are nearly insurmountable: "You're allowed to get married, but if you want to leave, it's almost impossible... You don't share the same rights as an adult. You can't enter into a lease; you can't go to a shelter; you can't hire a divorce attorney," Tasneem explains.

Both Johnson and Pollard have founded organizations to support survivors, and they say speaking out about their experiences has been life changing. "Talking is a part of the healing process," says Johnson, who created the Svon Foundation, which advocates for abuse survivors in Florida. She has published a memoir, and encourages other survivors to write and share their own experiences. "They think life is over because they have experienced being abused. No, it's not over. It's really just beginning," she says.

Pollard's Kentucky-based organization, Survivor's Corner, also helps abuse survivors speak out. "We've had folks go through our programmes who now are working on their own legislation," she says. "We've also had people that have gone on to become volunteers."

As for Tasneem, she urges researchers and policymakers to look beyond the numbers of registered, legal marriages, and into informal unions like the one that ended her own childhood. And she wants to see broader support for the movement to end child marriage. "How many of us have to come forward and share our horror stories for some action to be taken?" she asks. "It shouldn't just be all on the survivors. We need more help."

found in many cultures but is always more common among the poor, especially in rural areas, and this is exacerbated when households suffer economic difficulties, including in times of crisis and displacement.

Despite the introduction of universal, free primary education in many countries, the poorest families still face financial barriers in covering costs for transportation, books and uniforms. Tuition fees are still frequently charged for secondary school. Gender inequality in educational attainment (disfavouring girls) is particularly obvious in secondary education (Sperling and Winthrop, 2015), accelerating girls' trajectories into marriage and motherhood.

Bought and sold

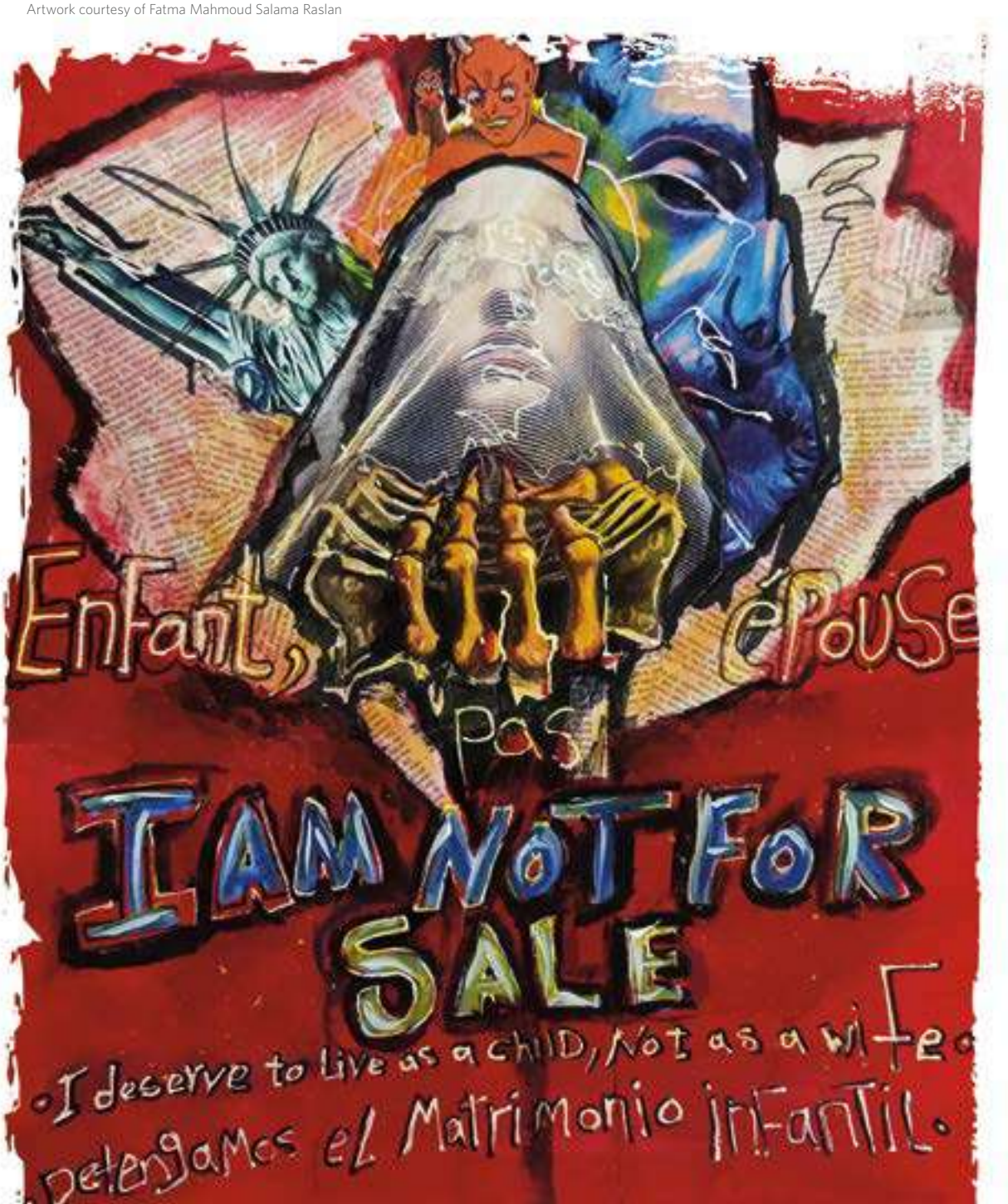
Financial transactions around marriage, such as dowry and bride price, also contribute to a high prevalence of child marriage (Parsons and others, 2015; UNFPA, 2012a; Malhotra, 2011; UNICEF, 2005). Often, poor parents justify marrying girls early as a way to secure their economic future, or they may regard daughters as an economic commodity and a way of settling familial debts or disputes (Parsons and others, 2015; Amin, 2011).

Dowries are paid by a bride's family to the groom, nominally for the upkeep of the wife, and bride price is paid by the groom or his family to "purchase" the bride. Many argue that these practices reinforce child marriage because younger girls require smaller dowries or command higher bride prices—a younger woman or a girl is perceived to be more valuable in that she has more years

ahead of her for childbearing and domestic service (Lee-Rife and others, 2012).

In the case of dowry, the rationale is that as a girl grows older, she will have fewer suitors and the family will have to increase dowries in order to "get her off their hands". Girls may be viewed as a financial burden, which increases if marriage is delayed, as a larger dowry needs to be paid (Delprato and others, 2015). In Nepal, parents opt to marry their daughters off while young as a way of reducing this cost (Onduru, 2019). With bride price, the benefit is more direct: a girl can fetch a higher price when she is young and, at the same time, the financial burden of providing for her is removed from her family (Kalamar and others, 2016).

Artwork courtesy of Fatma Mahmoud Salama Raslan



Whichever system is in place, dowry and bride price represent the "commodification" of girls and women—an egregious violation of their human right to make their own life decisions, including on marriage. Because of this, and other negative social consequences, payment of dowries or bride prices has been banned in most countries, but enforcing such bans is difficult. In India, which has the most experience in trying to end the dowry practice, the Dowry Prevention Act has been in place since 1961 and is enforced through different sections of the Indian penal code, but the practice remains widespread (Chiplunkar and Weaver, 2019).

Child marriage increases during times of hardship

Child marriage has been shown to increase during humanitarian crises caused by natural disaster and conflict. In Yemen, over 65 per cent of girls are now married before the age of 18 compared with 50 per cent before the conflict started (UNICEF, 2017). In Lebanon, 41 per cent of young displaced Syrian women are married before 18 (Bailey-King, 2018). In refugee camps in Jordan, at the beginning of the Syrian conflict in 2011, 12 per cent of marriages involved a girl between the ages of 15 and 17: by 2018, the figure was 36 per cent (Lemmon and Hughes, 2018).

There is some evidence that the economic value of girls increases during times of economic hardship for the family. In Tanzania, for example, when periodic drought led to income shocks because of crop failures, marriages of girls to obtain a bride price increased (Corno and Voena, 2016). The study in Tanzania also suggested a correlation between child marriage and the effects of climate change. If rural communities are subject to economic hardship because of loss of income due to drought, flooding or increased storm activity, and in the absence of any other insurance mechanism, they will have to resort to what families may see as a tried-and-true method to reduce household expenditures and, possibly, increase income—namely "selling" their daughters.

Another driver of child marriage in crises is the increased risk of sexual violence and assault that accompanies the weakening of social institutions. In such situations, some families see marriage as a way to protect the girls' "honour" and, by extension, that of the family (Lemmon and Hughes, 2018; Lemmon, 2014).

Furthermore, girls deprived of educational opportunities during crises are then seen as remaining "inactive" at home, furthering the perception that marriage is a positive transition for girls with limited options.

Finally, conflict and its related displacement have altered the social process of marriage, resulting in shorter engagement periods, lower bride prices, changes in cousin marriage practices and a reduced age at first marriage (UNFPA and others, 2018).

Consequences

Child marriage brings consequences that violate the basic rights of girls. Many of these violations are expensive and impossible to mitigate, correct or reverse—truncated education; poor health, often related to pregnancy and childbirth; the threat and actual experience of gender-based violence; social exclusion, leading to depression and even suicide; restricted mobility;

and domestic responsibilities. These combine to undermine the employment and earnings potential of girls forced to marry young. The impact reverberates beyond the girl to perpetuate the cycle of poverty for her family and community.

Early pregnancy and childbirth

One of the foremost harmful results of child marriage is that it generally leads to early pregnancy and early childbirth. Girls are usually not ready physically, emotionally, intellectually or financially to be mothers at such young ages. They are more likely to die due to complications in pregnancy and childbirth than women in their 20s, and their children are more likely to be stillborn or die in the first month of life.

Premature motherhood is common among child brides. In sub-Saharan Africa, an analysis of Demographic and Health Surveys for 34 countries found that, among women aged 20 to 24 who were married before the age of 18, 96 per cent had had children. Of these, 56 per cent had given birth within the first year of marriage and 28 per cent had had another baby less than 24 months after the first birth (Yaya and others, 2019). In Latin America and the Caribbean, 86 per cent of women who had married or were in a union before the age of 18 had given birth before they reached 20, as opposed to 34 per cent who married after the age of 18 (UNICEF, 2019b). In India, of women who had married before the age of 18, 60 per cent had given birth before they reached 18, and 79 per cent before the age of 20 (UNICEF, 2019c).

Nearly 95 per cent of births among adolescents take place in developing countries, and in these countries, about 90 per cent of births to adolescents aged 15 to 19 occur within marriage (WHO, 2008). Complications of pregnancy and childbirth are the leading cause of death for adolescents aged 15 to 19 globally (WHO, 2018a). A World Bank study suggests that the lifetime opportunity costs related to adolescent pregnancy range from 1 per cent of annual GDP in China to 30 per cent in Uganda (Chaaban and Cunningham, 2011).

Risk of death and injury in childbirth

Child marriage can cost a girl her life. The risks of maternal death are about 28 per cent higher for mothers aged 15 to 19 than they are for mothers aged 20 to 24, although among risk factors the age of the mother may not be as significant as other factors associated with child marriage, such as poverty and lack of access to services (Blanc and others, 2013). The maternal mortality ratio (number of deaths per 100,000 live births) in 2010 was 504 for mothers aged 15 to 19 in sub-Saharan Africa, compared with 416 for mothers aged 20 to 24. Similarly, in Asia, the numbers were 269 versus 201 and in Latin America 190 versus 164. Delaying the birth of the first child, even by a couple of years—until a woman is 20—significantly reduces her chances of maternal death (Blanc and others, 2013).

One of the major risks of girls having babies too young is obstetric fistula, a preventable condition where vaginal delivery results in a hole between the birth canal and bladder and/or rectum, leaving the woman incontinent (Cook and others, 2004). Incontinence often results in a woman being rejected by her husband and becoming an outcast in her community (Miller and others, 2005).

Obstructed labour causes approximately 90 per cent of obstetric fistulas in developing countries.

Obstructed labour is disproportionately common among girls giving birth before the age of 18 as a result of what is known as "pelvic immaturity", when the size and diameter of the girl's pelvic bone combine with the smaller size of the pelvic opening to trap the baby in the birth canal. The soft tissue of the vagina is trapped between the baby's head and the bony pelvis and the pressure opens the fistula (Cook and others, 2004). The number of years since a girl started menstruating (menarche) has a direct bearing on her ability to safely deliver.

Studies in Nigeria and Ethiopia show a disproportionate number of adolescent mothers suffer from obstetric fistula, and in Nigeria 46 per cent of obstetric fistulas occurred on first delivery (Miller and others, 2005).

It is estimated that 2 million to 3.5 million women live with obstetric fistula in the developing world, with 50,000 to 100,000 new cases every year (UNFPA, 2019a). UNFPA together with other organizations dedicated to reproductive health and rights has moved the prevention and treatment of obstetric fistula to the top of its programmatic agenda.

Poor health and nutrition of babies born to child brides

Among mothers younger than 18, numerous studies have found an increased likelihood of neonatal death and stillbirth, low birth weight, and infant and child disease and death (Fall and others, 2015). But it is difficult to separate out the other factors that contribute to such outcomes, such as low educational attainment, poor nutrition of the mother and child and access to health services. One comprehensive study in India did find that when controlling for all other factors, the children of women married as minors were significantly more likely to have stunting or be underweight—two of the most important indicators of child well-being (Raj and others, 2009).

A study of stunting in South Asia and Africa found that mothers who gave birth before the age of 18 had shorter babies—with a 6 per cent higher risk of stunted growth of babies due to the young age of the mothers in Bangladesh and India, and a 10 per cent higher risk in Burkina Faso and Mozambique (Yu and others, 2016), and this slower growth continued for the rest of the child's life (Fall and others, 2015).

Girls married young will have more children

A woman who starts bearing children at an earlier age will have more children than her sisters who marry later (UNICEF, 2019b, 2019c; Yaya and others, 2019).

A girl who marries at the age of 13 has 26 per cent more children on average over her lifetime than if she marries at 18 or later, according to a 2017 World Bank study of women who married young in 15 countries. Even if she married at 17, she would still have 17 per cent more children than if she had waited to the age of 18 or beyond (Wodon and others, 2017).

The consequences of starting early and of having more children are clear: women who marry in their early years spend their adolescence and 20s in the home, caring for young children without the possibility of continuing their education or developing skills and employment outside of the household. They become

wedded to a lifetime of domestic burdens, unintended pregnancies, large families and financial dependence on their husbands.

Girls who marry early rarely continue their education

Child marriage correlates with an abrupt end to schooling, higher rates of illiteracy and worse educational outcomes, undermining girls' prospects for entering the paid labour force and gaining economic self-sufficiency (Wodon and others, 2017a; Delprato and others, 2015; Nguyen and Wodon, 2014, 2012, 2012a; Field and Ambrus, 2008; Lloyd and Mensch, 2008; Adler and others, 2007).

Girls who marry and start having babies rarely continue their education or return to it in later years. Married girls are rarely found in school because of legal or societal restrictions or the need to assume domestic duties once married (Delprato and others, 2015). This has major consequences for their independence and for their ability to be productive and contribute to their families, communities and societies. Also, it impacts negatively on their own children's likelihood of continuing their education beyond primary school and escaping the cycle of early marriage, many children and poverty.

The statistics are alarming and disturbing. A review of 36 Demographic and Health Surveys in 31 sub-Saharan African countries and five in South Asia looked at women aged 20 to 29 years and the ages at which they married. Girls who were married before the age of 18 averaged only 2.9 years of schooling in the African countries and 3.9 years in those in Asia. This doubled in the young women married at the age of 18 or older, with an average of 5.3 years of schooling in Africa and 7.7 years in Asia. This disparity was reflected in literacy: only 17 per cent of African women and 35 per cent of Asian women who had married before the age of 15 were literate while among their sisters

Mural by Maia Bobo in partnership with TackleAfrica, Burkina Faso

who had married at 18 or later, the percentages were 53 and 75 per cent, respectively (Delprato and others, 2015).

Girls with the least education are at increased risk of child marriage and, in turn, girls who are married are at increased risk of leaving school early. Child marriage and the early pregnancies associated with them typically account for between 15 per cent and 33 per cent of school dropouts (Nguyen and Wodon, 2012; Lloyd and Mensch, 2008).

Postponing the decision to marry young by just one year would increase educational attainment among young women in sub-Saharan Africa by 0.54 additional years of schooling and by a 22 per cent increase in literacy (Delprato and others, 2015).

Gender-based violence

Many studies have shown that the quality of life for women married younger than 18 is significantly less positive than for women who married later. Being subjected to gender-based violence is one major reason for this. Globally, past-year experience of physical and/or sexual violence was higher among women who married as children (29 per cent) compared with those who married as adults (20 per cent) (Kidman, 2017). Child marriage perpetuates gender-based violence because it is characterized by spousal age gaps, power imbalances, restricted female autonomy, social isolation and feminine and masculine norms that accept and justify intimate partner violence. The use and even the threat of violence is a fundamental enforcer of male control over young females.

In India, one third (32 per cent) of women who had married before the age of 18 had experienced physical violence at the hands of their husbands versus 17 per cent of those who had married after 18, according to a large-scale survey of more than 8,000 women in five states where child marriage is prevalent (Andhra Pradesh, Bihar, Jharkand, Maharashtra and Rajasthan) (Santhya and others, 2010). Not only did women who had married at an early age suffer more domestic violence, they were more likely to feel that such violence could be justified in certain circumstances—two thirds of the child brides had this view as opposed to half of those who had married later (Santhya and others, 2010).

Lasting psychological damage

Violence—physical, sexual, emotional—and early pregnancy have lasting effects on girls' mental health. Child marriage comes with the pressure to raise children while girls are still children themselves and have limited knowledge about sexual and reproductive life (Yaya and others, 2019).

Child marriage can also lead to social isolation, stress, depression and a sense of powerlessness (Delprato and others, 2017; Duflo, 2011; Nour, 2009).

A study carried out in the United States showed an association between child marriage and a wide range of behavioural disorders, including nicotine dependence and alcohol abuse, as well as psychological disorders (ICRW, 2016a; LeStrat and others, 2011).

In 2013, researchers interviewed girls aged 10 to 17 in the Amhara region of Ethiopia and found that girls who were either married, promised in marriage or who had received a marriage offer were significantly more likely

than other girls to have had suicidal thoughts in the previous three months. Strikingly, they were also two times more likely to have attempted suicide (Gage, 2013).

In Niger, a survey of 2,463 women found significantly decreased psychological well-being among girls who married before the age of 15 and dramatically lower well-being among those who married aged 12 or younger. The survey used a standard measure of psychological well-being and was conducted in 2016 by the International Center for Research on Women. The researchers concluded that for these very young girls who were "forced into marriage (often to a stranger)… the burden of marital responsibilities, most notably [the] partner's sexual demands and childbearing and child-rearing, led to significant emotional distress and depression" (ICRW, 2016a).

Helping girls to make their own informed choices

The very first efforts to end child marriage emerged in the first half of the twentieth century, led by social reform movements in South Asia. These efforts succeeded in stimulating the establishment of laws forbidding child marriage, such as the Child Marriage Restraint Act of 1929 in pre-independence India, and sporadic efforts to improve girls' access to education (Khoja-Moolji, 2018). Although wider efforts to end child marriage began to emerge in the 1990s, such as the Bangladesh female secondary school stipend project (Schurmann, 2009), it was not until the 2000s that there was significant growth in the number and coverage of community-based programmes—for example, Berhane Hewan in Ethiopia (Erulkar and Muthengi, 2009), Ishraq in Egypt (Sieverding and Elbadawy, 2016), and Prachar in India (Subramanian and others, 2018). Implemented by non-governmental organizations, these programmes provide girls with life skills, comprehensive sexuality education, health information and financial literacy, and provide their families with incentives as well as organized community conversations and mobilization.

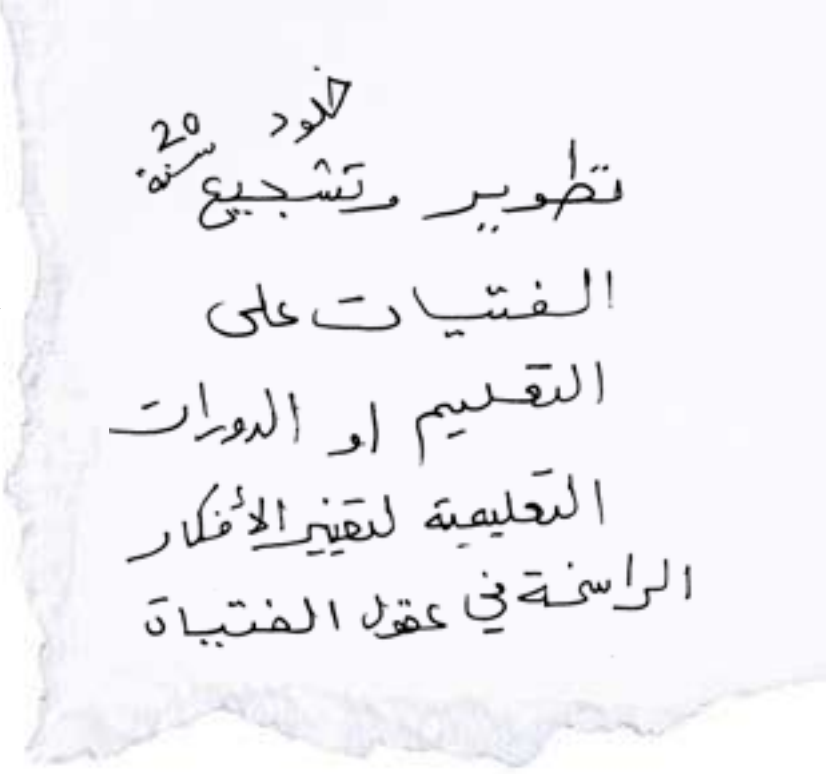
Building on initiatives introduced in the 2000s, the number of community-based programmes addressing child marriage, led by international and local NGOs, has grown steadily. These programmes have demonstrably delayed age at marriage and have contributed to the evidence base. For example, Balika in Bangladesh, led by the Population Council, has shown declines of up to one third in child marriage in programme communities. Early marriage and cohabitation fell by half among adolescent girls participating in the Empowerment and Livelihood for Adolescents programme led by the non-governmental organization BRAC in communities in Uganda (Bandiera and others, 2018). In Guatemala, the life skills and leadership programme Abriendo Oportunidades has demonstrated impact for rural indigenous Mayan girls: among participants, 97 per cent did not marry between 13 and 18 years of age compared with a national average of 88.7 per cent in 2006. The programme costs $106 per girl for about 100 hours of participation (Catino and others, 2012).

The growing momentum on ending child marriage, evidenced by the adoption of a target on child marriage in the Sustainable Development Goals and the creation of the UN Global Programme to Accelerate Action to End Child Marriage in 2016, has brought to the fore

questions on how best to accelerate large-scale declines, while ensuring that marginalized girls, families and communities are not neglected in investment plans. The approach has evolved from predominantly providing public messaging on the dangers of child marriage to understanding and addressing its structural drivers.

A study of micro- and macro-level drivers of changes in the prevalence of child marriage in South Asian countries concluded that, at the macro level, drivers for regional wealth, above-average growth in a region's economic activity, a lower mean age of childbearing, regional fertility rates and access to media are predictors that associate negatively with child marriage. In particular, there is a robust causal relationship between economic development and prevalence of child marriage (UNICEF and UNFPA, 2018). Accordingly, programmes are increasingly seeking sustainable service delivery at scale by integrating with platforms such as education, health and social protection systems, promoting women's economic empowerment and access to opportunities, and seeking to drive social change and have an impact on harmful gender and other social norms that underpin the practice.

One of the most effective strategies for delaying child marriage is to increase girls' education. While lower educational attainment is a risk factor for child marriage, higher educational attainment is a protective factor. A study by the World Bank and the International Center for Research on Women found that, in 15 sub-Saharan African countries, each additional year of secondary school attendance significantly reduced the chance of girls being married before the age of 18 and the likelihood of giving birth before the age of 18 (World Bank and ICRW, 2017).



Encourage and better girls through education and training courses to change the embedded stereotypes.

Khuloud, 20 years old, Jordan

Successful education-related interventions include the provision of cash transfers conditional on school attendance; or support to cover the costs of school fees, books, uniforms and supplies (Kalamar and others, 2016). Examples of successful cash-transfer initiatives include Apni Beti Apna Dhan in India, the Zomba Cash Transfer Programme in Malawi and the Female Secondary School Assistance Programme in Bangladesh.

In Burkina Faso, Ethiopia and Tanzania, the Berhane Hewan programme reduced child marriage by an average of 24 per cent, using various strategies including conditional economic transfer—a goat or chicken—for good class attendance, school supplies as an incentive to remain at school and community awareness to address cultural and social norms (Erulkar and others, 2017).

Bringing girls together to learn life skills, play sports and in some cases gain literacy and numeracy, can reinforce positive outcomes for girls. Such programmes help them overcome social isolation and create networks of social capital. Comprehensive sexuality education and life skills training empowers girls and builds their self-esteem by promoting better health and enhancing their opportunities in the formal employment sector. Comprehensive sexuality education, when based on strong curricula that challenge unequal power relations, can promote positive masculinities among boys. Participants in these types of programmes also receive information on sexual and reproductive health and rights to help them learn about their bodies, menstruation, contraception, prevention of sexually transmitted infections, and gender and power in relationships.

In Mozambique, the Rapariga Biz programme has reached more than 300,000 girls and trained 4,000 mentors, providing sexual and reproductive health services, engaging schools and the justice sector, and using such techniques as a sexual health hotline, SMS messages and radio programmes at the relatively low cost of $120 per trained mentor and $10 per girl (Hilber and others, 2019).

Laws can also make a difference. While studies have shown no direct causal relationship between legislation on the minimum age of marriage and child marriage prevalence, laws can nevertheless have a signalling effect to the wider population, conveying current norms (Svanemyr and others, 2013). An appropriate constellation of laws that set the minimum age of marriage at 18, recognize and address marital rape and ensure the right to divorce and the right to claim custody of children, can give girls and women judicial recourse and a path to a life after marriage (Equality Now, 2014).

However, national laws have not caught up with the commitments made in international treaties, which hold that the minimum age of marriage should universally be 18. In as many as 20 countries the minimum age of marriage without obtaining special parental or judicial consent is 17 or below.

Investments to end child marriage

If initiatives and programmes to empower girls, increase their educational attainment and enhance their life skills were replicated, scaled up and fully funded, child marriage could be eliminated by 2030 in 68 countries. The total investment needed to reach this goal is $35 billion over 10 years (UNFPA, 2020). Without this investment, the world will not meet the target set in the Sustainable Development Goals to end child marriage by 2030. Accelerated and expanded action is needed.

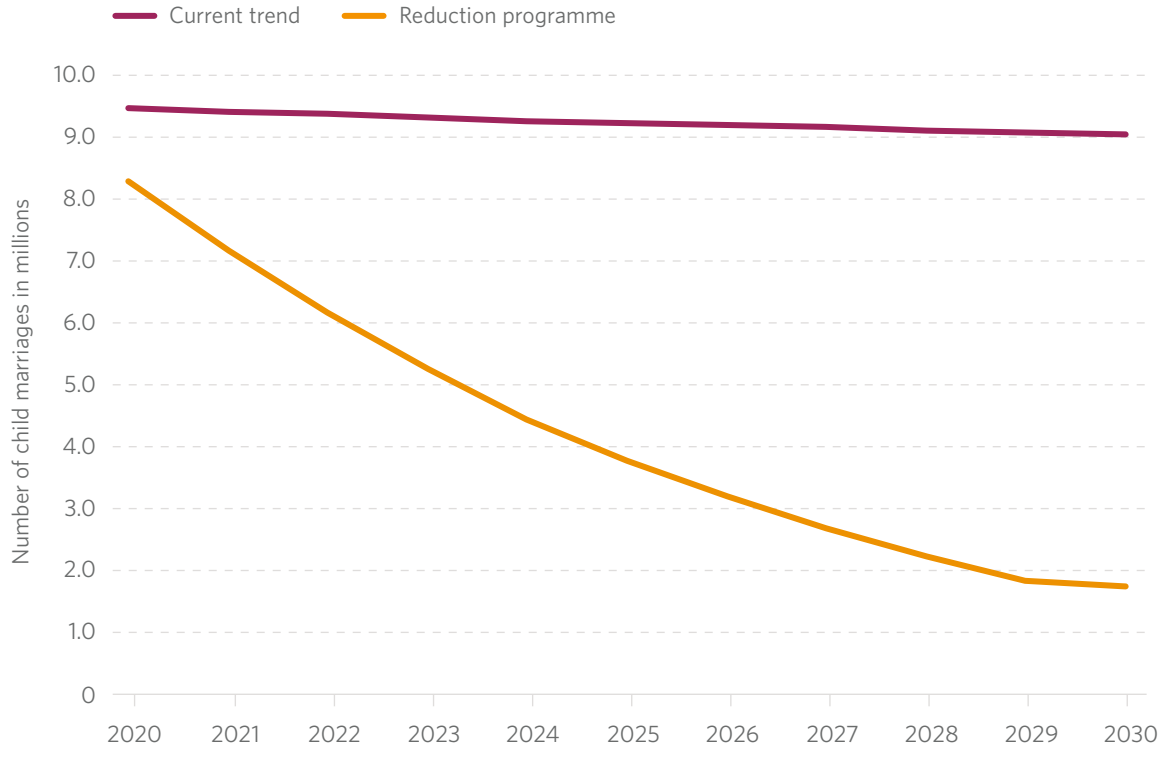
One challenge is to determine which approaches work best and are most cost-effective. A modelling exercise was undertaken for 68 countries, with the states of India being modelled separately. Figure 5.1 shows the number of child marriages with and without the reduction programme. The package of interventions was drawn from programmes that changed social and cultural norms, provided enhanced life skills and increased school enrolment for girls, and that did so by increasing school accessibility, improving

school infrastructure (girl-friendly schools) and providing incentives to stay at school. Starting with a relatively small proportion of girls, it was assumed that the programmes would be progressively expanded to cover almost all girls at the age of 15 by 2030.

Ending child marriage is ultimately about upholding the rights of girls and women everywhere. When all girls are able to enjoy their rights, benefits accrue to all—including better health, more productive labour forces and progress towards gender equality. Marriage at the age of 13 is almost a guarantee that a girl will spend her life poor and uneducated, bearing and caring for many children. Marriage before the age of 18 poses multiple risks for girls: they may suffer increased handicaps to their health, their own well-being and that of their children and family, and these deleterious effects will multiply to damage society as a whole.

An end to girls' hopes and dreams; a human rights violation and a harmful practice; an obstacle to ending poverty and inequality and achieving growth and stability: the costs of child marriage are so large that its elimination must become a global priority.

FIGURE 5.1 **Projected number of child marriages with and without marriage intervention programmes, 2020 to 2030***



* 68 countries
Source: VISES modelling

DEFIANT

ACTIONS for a world FREE from harm

HARMFUL PRACTICES ARE TENACIOUS. States pass laws to stop them. Awareness campaigns urge people to rethink their actions. Families and communities come together and agree to abandon the mutilation of girls' genitals or push up the age of marriage. Yet the harm goes on, destroying lives, violating rights, in every region of the world.

Gender discrimination causes this harm. Norms that are deeply rooted in families and communities insist that a girl must look or act or exist in certain ways, despite what she herself might choose, and regardless of her rights and well-being.

Such norms both shape—and are shaped by—broader economies and societies. A child bride is sent into marriage by her family and community. But she may be kept there by many other pressures driven by stark imbalances in rights and power. These might include the belief that a girl from a poor community does not warrant an education, coupled with a failure to invest in a suitable nearby school. An economy may be structured to channel her, at best, into a low-paying, poor-quality job that hardly provides a viable economic alternative to early marriage. In the meantime, her entire society depends on the care work she and many other women and girls do at home—for free.

Despite some progress, not nearly enough has been done to end harmful practices in either developing or developed countries. This is largely because not nearly enough has been done to end gender discrimination. Wherever girls and women gain rights and choices, and an empowering conviction in their own agency and value, harmful practices tend to decline. Wherever women and girls do not see such gains, they remain vulnerable to a lifetime of continued abuse and marginalization.

Solutions to stop harmful practices will vary across countries. In general, they must encompass prevention, protection and care. They must be fully aligned with achieving gender equality and women's rights at the level of families as well as in institutions and across whole societies. And they must be endorsed as essential (and investment-worthy) steps towards a more peaceful, fair world for everyone.

Above all, solutions must be aimed at getting to zero harmful practices, leaving no country or community behind. This implies a global effort, since practices are insidious and frequently occur beyond the reach of laws and the data that might track their spread.

Only action on a universal scale can fulfil a long history of globally endorsed human rights agreements. Only this will be enough to keep the promises made in the Programme of Action of the 1994 International Conference on Population and Development (ICPD) as well as the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals.

Gender equality: let's get serious

Without substantial progress on gender equality, progress on eliminating harmful practices will remain incremental, with millions of women and girls at risk. In 2020, the world marks the twenty-fifth anniversary of the Fourth World Conference on Women, which built on the 1994 ICPD by elaborating far-reaching commitments to women's rights and gender equality in all areas of life. That vision has only been partly realized, however, amid rising inequalities and economic exclusion around the world, and a strengthening pushback against gender equality (Commission on the Status of Women, 2020).

Gender equality is more visible in public discourse than ever before, from social media campaigns to high-profile cases against sexual misconduct. Yet when it comes to actually getting the job done, the shortfalls are stark. Attempts at "mainstreaming gender" in health

programmes, for instance, have often fallen flat, as gender equality becomes a goal that is "everyone's problem but no one's responsibility" (Heymann and others, 2019). Far too few men use their political power and influence to drive rapid progress on gender equality. Funding for gender equality initiatives lags significantly behind what's needed to ignite lasting change.

Elaborating a full menu of options to achieve gender equality goes far beyond the scope of this report. But this report does call for consistently linking actions to end harmful practices with achieving gender equality and women's human rights. This requires disrupting root causes of inequality, including social relations as well as patterns of economic and political power that continue to favour men (Heymann and others, 2019). Over 100 countries with nearly 3 billion people still restrict women's participation in the workplace (World Bank, 2019, 2018), limiting opportunities and prospects for empowerment that might reduce harmful practices. Laws ban women from working in certain industries, or

Artwork courtesy of Fatma Mahmoud Salama Raslan

from registering a business or opening bank accounts without the permission of their husband. Only about half of countries have laws requiring equal pay for equal work.

Countries as diverse as Bangladesh and the Republic of Korea have shown that when girls and women have better economic options, harmful practices such as child marriage and son preference begin to decline, sometimes dramatically (Naved and others, 2001; UNFPA, n.d.). In Georgia, for each 1 per cent increase in female employment outside agriculture, a sex ratio at birth skewed in favour of males declined by 0.25 per cent (UNFPA and The European Union for Georgia, 2019). Higher female employment rates coincided with the introduction of social security, pension and other social policies mitigating pressures on families as the primary source of socioeconomic support (UNFPA, n.d.).

Making much more of national women's institutions

Women need more positions of power, as a matter of justice and to set new, transformative agendas centred on their equality and rights. One starting point could be in the dedicated national gender equality "mechanisms" now in place in 192 countries: these range from fully fledged women's ministries to gender equality focal points in other national institutions (Commission on the Status of Women, 2020). Such mechanisms help orient national plans, policies, budgets and institutions around achieving gender equality and the empowerment of women, including by spearheading action plans and the removal of discriminatory legislation. They could be well-positioned to lead a drive to eliminate harmful practices, given their explicit commitment to women and women's rights, and their existing work on the multiple and mutually reinforcing dimensions of gender equality. Yet many remain significantly underfunded, with little capacity or authority.

If governments and their partners closed these gaps, national women's mechanisms could become central champions of gender equality and lead advocacy for multiple legal and policy reforms to end harmful practices, perhaps working in tandem with natural allies such as women's parliamentary caucuses.

Governments may also consider systematic gender assessments of laws as well as social and economic policies that encourage the undervaluing of girls and women, perhaps building on the drive by UN Women, the African Union and several other international organizations to fast-track the repeal or revision of gender discriminatory laws in 100 countries by 2023. Among many possibilities, insights gained from such a process can guide reforms to end legal discrimination related to property rights, education, employment, pension benefits, inheritance, marriage, divorce, child custody, and sexual and reproductive health and rights.

From their central position in government, national gender equality mechanisms could build bridges to other national bodies with central roles in stopping harmful practices, such as in health, education and social protection. Together, they can mobilize the diverse array of people who play a part, from religious leaders to teachers, youth peers, law enforcement, health-care providers, parents and policymakers. As watchdogs, national gender equality mechanisms could track national development plans and

budgets for actual impact on gender disparities. They could monitor potential contradictions between different policy arenas, so that progress in one place is not frustrated by regression in another. Since data on harmful practices are often scant, they could work with national statistical systems to close gaps, including in line with Sustainable Development Goal indicators on early marriage and female genital mutilation.

Mobilizing women's movements

National gender equality mechanisms often have close links with women's movements and groups, giving them unique insights into women's concerns and priorities, and allowing a reach from the national to the local level, and into populations facing multiple forms of marginalization and stigma. For their part, women's groups know many of the solutions to gender discrimination and harmful practices, based on a now long record of research, activism and lived experience. But, like national women's institutions, they too are significantly underfunded (Commission on the Status of Women, 2020).

Scaling up investments in both national gender equality mechanisms and women's groups could empower the two to work more systematically together on developing a groundswell of support for changes in households and communities, as well as in services and policies. They could convene cross-issue alliances and coalitions, and collaborate around a new generation of feminist organizing, research and leadership. In a time of pushback against advocacy for gender equality, national gender equality mechanisms could open doors for women's rights organizations to influence and monitor gender-responsive laws and policies.

Pass a law, not a panacea

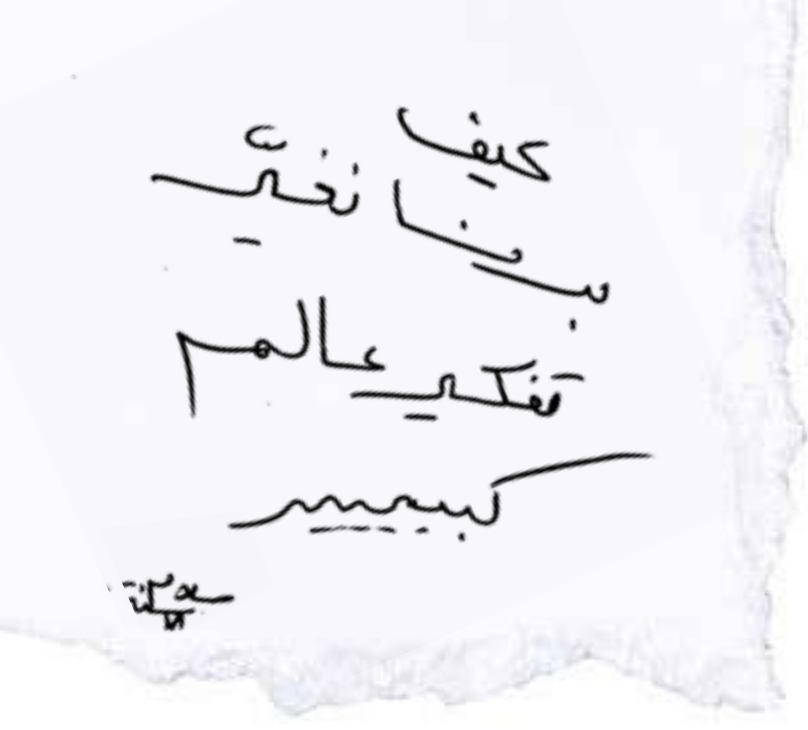
Passing laws against harmful practices is not a panacea, but it is a powerful statement of disapproval and is in line with State obligations under international human rights instruments. It speaks as well to government commitments under the 2030 Agenda, the ICPD Programme of Action and the Beijing Platform for Action.

Keeping laws grounded in human rights

In recent years, countries in all regions of the world have made progress on legislation to combat violence against women (Commission on the Status of Women, 2020). As part of this process, and in line with the obligations of international human rights conventions and treaties, every country should include explicit prohibitions on harmful practices. Laws should be grounded in human rights and offer a comprehensive framework for prevention, protection and mitigation of harmful practices. One example is the Model Law on child marriage developed by the Southern African Development Community (SADC-PF and others, 2018).

Laws must consider the "totality of rights" to help guarantee that rights in one area do not contradict those in another. This occurs, for instance, by protecting people under the age of 18 from child marriage while also upholding their rights to sexual and reproductive health and choices in line with their evolving capacities.

Laws to stop harmful practices should ideally be embedded in a broader legal framework committed to the principles of gender equality and non-discrimination (Commission on the Status of Women, 2020), as can be done in a



How can we change the mindset of this big world!

Salam, 18 years old, Jordan

Constitution. This can encourage, for instance, the removal of discrepancies arising in plural legal systems, where some communities continue to practise traditional but often discriminatory personal laws. It would set a standard for all levels of law, national as well as subnational.

Mitigating risks of non-compliance

Since legislating against harmful practices can have the unintended effect of driving them underground, measures may also be needed to mitigate these risks. Laws need to operate in tandem with a clear understanding of the social and economic determinants of harmful practices, and their evolution over time. International human rights bodies have underscored backing legislation with appropriate budgets, as well as effective enforcement measures and monitoring to track impacts in practice (OHCHR, n.d.).

Managing the risks of non-enforcement, community rejection and clandestine practice can build on the meaningful participation of affected individuals and communities in developing and then regularly monitoring and evaluating laws and associated policies and services (Gruskin and others, 2010). Since gender discrimination and the "permitting" of harmful practices can appear at many points in legal systems—for instance, when a police officer sides with a perpetrator and refuses to process a complaint—another aspect involves training and sensitization among police and judicial officials. Differentiated penalties under the law could impose heavier sanctions on people who should be on the frontline of prevention. These include health-care providers participating in the medicalization of female genital mutilation, or "specializing" in sex-selective abortion for which there is no medical justification.

Make plans that make links

Comprehensive, adequately funded national action plans on harmful practices can offer an important complement to legal bans, providing a systematic focus on translating the latter into programmes and services. Such plans can orchestrate critical links across health care, education, justice, child protection, birth registration and other areas essential in ending harmful practices. They can aim to instigate behavioural and attitudinal changes to stop harmful practices as well as to open opportunities, such as girls' education, that will help sustain these changes.

Kenya, for example, has a national programme to end female genital mutilation that is underpinned by national laws and policy, and

includes an oversight and coordination board, community engagement, girls' empowerment programmes, partnerships with religious leaders, outreach to both traditional practitioners and medical personnel, and community services to report and respond to cases (UNICEF 2020b).

Where harmful practices cross borders, countries should come together to create and fund regional action plans, as has been done recently in East Africa (UNFPA, 2019b). This should include a mechanism for regional monitoring and accountability. It entails harmonizing national legislation and policies to stress the broad sanction of harmful practices, and limit the chances that people will cross borders to carry out harmful practices in more permissive jurisdictions.

Get the right services to prevent, protect, care—and empower

Public health, education and other services can offer significant reach in ending harmful practices, but they must be equipped to do so. They must operate in line with human rights principles and evidence of what works, and respond to needs expressed by the people, both women and men, who use them. In all communities, high-quality services need to advance the prevention of harmful practices, offer protection for women and girls at risk, and provide comprehensive care for those affected, including medical, legal, psychosocial and other essential services.

Education is viewed as one of the most successful drivers of transformation in the lives of girls and young women, including as a protective factor against harmful practices such as child marriage (Chae and Ngo, 2017). Cash transfers have had some success in keeping girls in school, but need to be accompanied by efforts to counteract the gender discrimination that often derails future opportunities for girls to secure employment. Schools must also be safe and located nearby, and have adequate facilities for girls and boys (World Bank, 2017).

The 2030 Agenda has called for universal health care, a goal that has renewed interest in strengthening health systems, particularly to reach marginalized communities with quality care. While there are many ways to do this, all should provide quality and appropriate sexual and reproductive information and services that include preventing and responding to harmful practices. In many cases, health-care professionals still encounter survivors of harmful practices, such as female genital mutilation, only if there is a medical complication (Creighton and Gill, 2010). They could be better equipped to identify and refer cases in women and girls who come for other services, and to understand who is at risk.

More regular, systematic training is particularly important for health professionals in maternity, obstetrics, gynaecology and sexual health (Creighton and Gill, 2010). This training needs to be carefully designed and managed, considering that harmful practices have deep roots, and in some cases, are being perpetrated by medical personnel. Cautionary tales come from programmes that, for instance, result in health practitioners wrongly believing that female genital mutilation is medically safe and therefore acceptable (Arango and others, 2014).

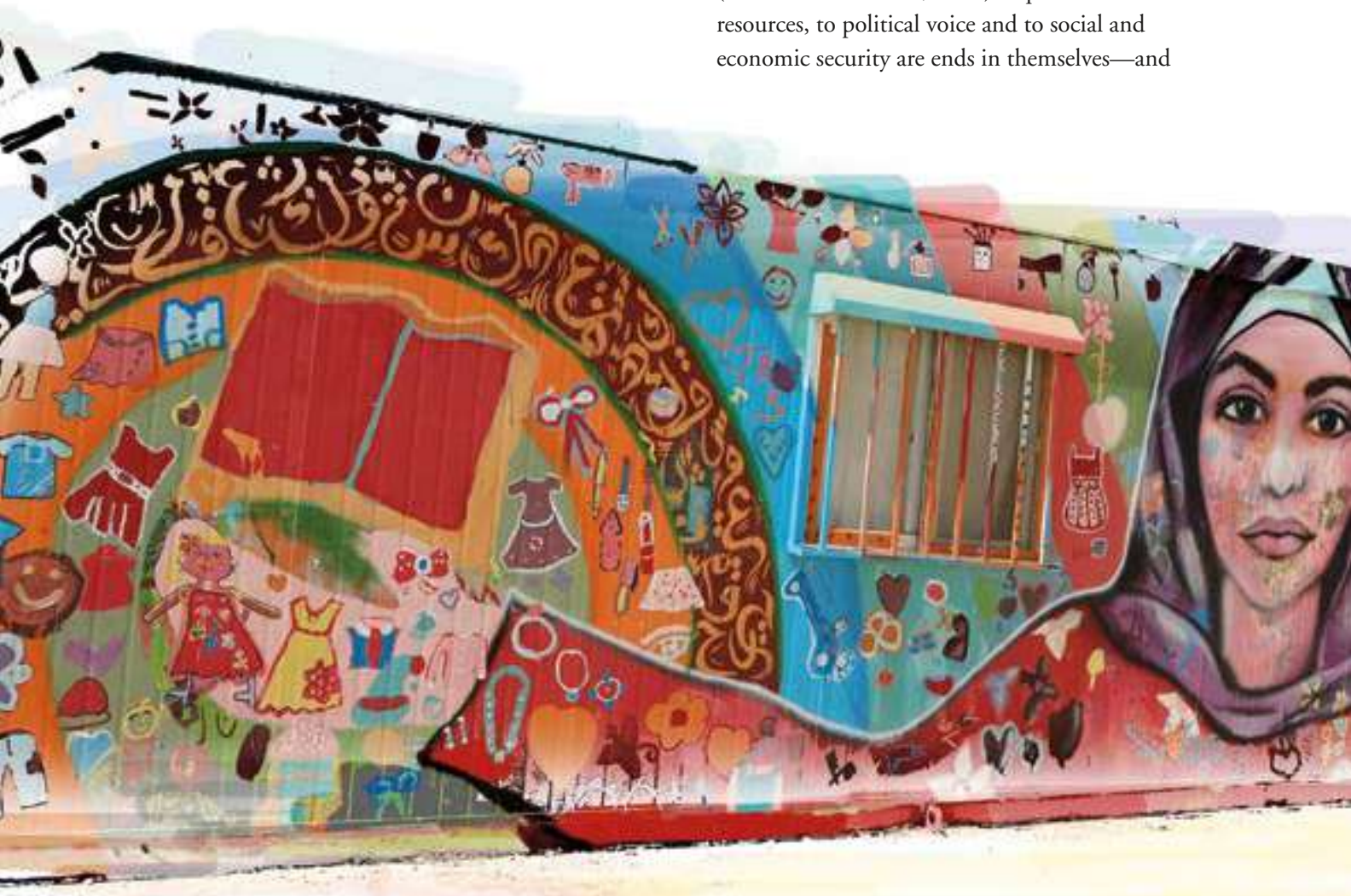
Change minds—and lives

Gender discrimination—and harmful practices—thrive on biased norms and stereotypes. While norms or stereotypes are just ideas, they can be powerful, destructive forces. At the same time, because they are ideas, they can be changed, no matter how deeply rooted they are.

To date, many programmes have worked with communities to transform norms around harmful practices. While some progress has been achieved, a relatively narrow focus is not enough. Broader norms around gender and women's subordinate status operate not just within a community, but also beyond it, intersecting with systems of power that trap millions of women and girls in situations of oppression and daily violations of their humanity (George and others, 2019).

Setting broader change in motion

While it is important to continue calling for individuals and communities to change how they think and act, as is done through social and behavioural change initiatives, changing norms on a larger scale—at the level required to end harmful practices—depends on rebalancing disparities in power across economies, governments, services, employment and so on (Malhotra and others, 2019). Equal access to resources, to political voice and to social and economic security are ends in themselves—and



can be just and convincing arguments to step back from harmful norms and practices.

Some broader shifts in norms happen organically over time, as is the case with the explosive growth of technology. Young girls know more about their rights and choices than ever before because the information is accessible through a mobile phone in the palm of their hand. Other changes are a matter of deliberate public policy, such as the choice to invest in universal, high-quality education. Girls are exposed to new ideas, and at the same time they can demonstrate, for all to see, how much they can achieve. In a short time, especially if girls can sustain their educational achievements by one day finding decent work, multiple communities across an entire society may begin to agree, for instance, that girls should stay in school instead of getting married (Malhotra and others, 2019).

Photo ©UNFPA Jordan

Sustaining momentum through services and communities

Health, education and other service providers, with their many foot soldiers reaching even remote communities, can serve as effective drivers of social norm changes. Hiring more female teachers where they are a minority can offer positive role models for girls and communities (Malhotra and others, 2019). Health-care providers can be enlisted in stopping the medicalization of female genital mutilation, and delivering consistent messages to families and individual patients around the many negative health consequences of harmful practices.

Within communities, more can be done to link social and behavioural change interventions with local institutions and services that can carry them forward (Malhotra and others, 2019). In Ethiopia, community surveillance mechanisms and women's development groups are involved in both following newborn girls to protect them from female genital mutilation and in reporting cases that do occur (UNICEF, 2020a).

Harnessing the power of information

Today's world is awash with sexist and violent language and images that deepen the hold of gender discrimination, stereotypes and the risk of harmful practices. Media, technology, corporations and advertising firms need to take leading roles in stopping such portrayals, and, along with the broader business community, begin changing corporate reliance on sexism to turn a profit (George and others, 2019). Creative firms could deploy skills in social marketing and develop innovative campaigns to celebrate women's progress and demonstrate new ways of thinking.

Rethink marriage and family formation

Marriage and the family are often seen as key to the survival and well-being of girls and women. Yet they are also a locus of discrimination and violence, including harmful practices. At the 2019 Nairobi Summit on ICPD25, held to mark and reinvigorate action on the ICPD Programme of Action, there was a concerted call to examine what happens in homes behind closed doors, and an emphasis on young people leading changes in the "culture" of relationships. A further issue is that where marriage is seen as the only legitimate relationship, other ways of living can be devalued and lead to denying people their rights (Burton, 2017).

Since States typically endorse marriage through the law, they should also use laws to ban marriages under the age of 18, in line with the Convention on the Rights of the Child. But they could also initiate broader examination of whether marriage in practice aligns with women's rights and gender equality, in line with the Women's Convention. This could lead to an exploration of how public policies, educational curricula, ready access to reproductive health care and tools such as awareness campaigns could better protect and support women and girls in moving beyond default settings and making their own choices.

Some "rethinking" is happening naturally in places where social and economic changes have given women and girls alternatives to marriage and more control over family formation. In other places, it could be encouraged through public discourse on how marriage might be one source of resources and respect, but other sources include guaranteeing women's equal access to land, paid labour, inheritance and education.

In Eastern Europe and Central Asia, a revival of patriarchy and patrilineal families coincided with the withdrawal of State services and rising inequalities in income, health and living standards. This was quickly followed by a rapid increase in skewed sex ratios at birth caused by gender-biased sex selection (UNFPA, 2015a). To push back against the devaluation of daughters and the perpetuation of discrimination, campaigns by UNFPA and UN Women in some countries of the region have used television shows, well-known male role models and other techniques to call on men to assume more responsibility for household tasks and model egalitarian family dynamics. Two priorities in most countries globally are to move towards universally available child and family care as part of relieving the burden of unpaid care work placed on women and girls, and to enact paid, flexible parental leave policies for men (UNFPA, n.d.a).

Tap the power of the next generation, especially girls and young women

Young people are some of the most effective advocates for abandoning harmful practices and ending gender discrimination. They know more about the consequences and their rights than ever before, and they have more options to connect with peers and gain support in the face of social pressure to conform. Emerging evidence suggests that younger generations reject gender-based stereotypes and son preference in China and elsewhere (WHO,

2011). In countries with a high prevalence of female genital mutilation, adolescent girls are more likely than older women to oppose the practice, by at least 50 per cent in some countries (UNICEF, 2020).

Around the world, young "digitally native" feminists are at the forefront of demands for systemic changes leading to justice and sustainability (Commission on the Status of Women, 2020). They include young women who have survived harmful practices and can make a powerful case as champions for their abandonment. Governments, international organizations and philanthropies could do much more to invest in them, so they have the resources and skills to build organizations and movements that can lead their generation in a new direction.

In schools, age-appropriate comprehensive sexuality education should be universally available, empowering young people with full knowledge of their rights and choices, and putting a central emphasis on gender equality and the empowerment of girls. Clubs for in- and out-of-school adolescent girls can provide opportunities to cultivate knowledge and self-confidence, develop mentorship and expand social networks. They can develop life skills, including through sports, as well as literacy and numeracy. Some evidence suggests that girls' clubs contribute to leadership skills and can be a springboard for civic action (Marcus and others, 2017).

In Uganda, some 1,500 girls' clubs offer games, music, sexuality education, financial literacy, vocational training and access to microfinance for young women trying to become entrepreneurs. Girls who have been members of the clubs for two years are 58 per cent less likely to be married early (World Bank, 2017).

Mobilize men and boys in the fight against harmful practices

Whether the issue is a child bride or a woman "cleansed" by female genital mutilation, men and boys are the "intended beneficiaries" of harmful practices (Sonke Gender Justice, n.d.). They also occupy many of the most powerful platforms to contest them, as heads of household, as musicians or athletes, or as religious, traditional or political leaders. Laudably, some are increasingly visible in standing against harmful practices, serving as trailblazers and mobilizers of other men and boys.

For men who are not yet committed feminists, self-interest can be a persuasive argument for change. Take, for example, the health and sexual consequences of female genital mutilation. These affect women first and foremost, but there are implications for their male partners as well. A study in Yemen, for instance, attributed a decline in support for female genital mutilation among men to their participation in health education and women's sexual and reproductive health programmes (Al-Khulaidi and others, 2013).

Men's groups in some countries offer opportunities for men who might otherwise never discuss such issues to speak more openly about them, learn more about sexual and reproductive rights and choices, and begin to question and change behaviours such as the use of violence to exert power (Salam, 2019). Education in general may be associated

with shifting men's attitudes to female genital mutilation, with one study in Ethiopia finding that a girl is twice as likely to be cut if her father has no education than if he has a high school education (Tamire and Molla, 2013).

More effective and lasting involvement of men and boys, however, depends on a closer examination of patterns of gender discrimination and power, including those embedded in the broader economy and society (Commission on the Status of Women, 2020). Men have to talk not only about defining new ways to express themselves, but actively step back from unfair privileges. Even in communities that as a whole are disadvantaged, gender still makes women and girls more marginalized and vulnerable, including to harmful practices. In times of crisis, where pressures are extreme, it is mostly girls who are sent into early marriages or trafficked for sex, not boys.

Bringing women, men, girls and boys together to deconstruct and understand gender dynamics has, on balance, proven more effective than initiatives for men and boys alone (Commission on the Status of Women, 2020). In Senegal, community dialogue between sexes and generations has been a key factor in improving these dynamics, with men explaining that they are now more engaged in "women's issues" and can better understand issues from a woman's perspective (UNFPA and UNICEF, 2013). More research is needed on how these kinds of community-based models can be scaled up, however, and what activities could complement them and enhance their impact in preventing harmful practices (Commission on the Status of Women, 2020).

Make technology work for good, not harm

Online violence against women is a growing concern, with younger women at particular risk (Commission on the Status of Women, 2020). Internet technology is used in some cases to perpetrate harmful practices, including the selling of child brides. Platforms with sexist content reinforce broader patterns of gender discrimination that underpin harmful practices.

Artwork courtesy of Fatma Mahmoud Salama Raslan

In 2018, the UN Human Rights Council reminded States and Internet businesses that online violence in any form violates the universally recognized right to live free from violence. It stipulated that international human rights law fully applies in digital spaces, and made a series of recommendations to enact new laws, regulations and enforcement accordingly. It underscored that businesses have an obligation to protect women's rights, including by moderating content and acting on complaints, among other measures (Commission on the Status of Women, 2020; UN HRC, 2018a).

The Council also pointed to the great potential of digital spaces to accelerate the realization of women's rights (UN HRC, 2018a). If some platforms offer misogynistic content, others provide scope for girls and young women to learn and shape movements to claim their rights. In Kenya, for instance, five girls developed the i-Cut app to help survivors and potential victims of female genital mutilation seek medical and legal help, report cases and find rescue centres (African Exponent, 2020).

Coding boot camps and hackathons for girls provide opportunities to develop more solutions like these, while easing the entry of girls into science and technology jobs that will position them to someday transform industries still heavily dominated by men.

Adopt a feminist foreign policy

Some international donors have played influential roles in financing programmes to end harmful practices in a variety of countries, in line with commitments to human rights and official development assistance. From that perspective, the fact that several countries have adopted a "feminist foreign policy" is promising. This includes the potential to increase official development assistance for gender equality as a primary programme objective from the current global average of only 4 per cent of foreign aid overall (Thompson and Clement, n.d.). Scaled-up support, including in humanitarian assistance, could encompass programmes to stop harmful practices, since nine of the 10 countries with the highest rates of child marriage are affected by conflict or crisis (Women's Refugee Commission, 2016; Commission on the Status of Women, 2020).

A "feminist foreign policy" should not be confined primarily to international development assistance, however, as is true of some models. A broader and more meaningful application would apply to all interactions between States and people. It would prioritize gender equality and women's rights and aim for an equitable world, backed by sufficient resources to achieve those goals. It would use different levers of influence, not just aid, but also trade, defence and diplomacy, to interrupt structures of power that sustain gender discrimination and manifestations such as harmful practices. It would be routinely informed by feminist perspectives.

In practice, such an approach would require looking at issues such as internationally mandated fiscal austerity programmes that cut social services, including those for preventing and responding to harmful practices among poor women and girls (Thompson and Clement, n.d.).

Their rights, their choices, their bodies

There is no "magic bullet" to stop harmful practices—and since a confluence of factors shape them, it is unlikely that one will be found. More understanding is needed of what works, including for specific practices in hugely diverse societies. But what we do know is that to get to zero, we have to move much faster.

A critical element is investing in the commitments that have been made, recognizing that without doing so the costs will be far greater. These will accrue in financial terms through health-care costs and losses to economic productivity, but the greatest toll is in lives lost or permanently harmed. The sums required are relatively small. For 31 countries where girls are most likely to undergo female genital mutilation, the cost of ending the practice would be relatively little: $2.4 billion over 10 years. Ending child marriage globally would cost about $35 billion (UNFPA, 2020). Greater investment in education and measures to achieve gender equality could catalyse these investments and accelerate progress.

The good news is that the tide is turning. More and more people are defying the persistent hold of harmful practices. Parliamentarians are passing effective laws. Traditional practitioners are putting down their tools. Mothers and fathers are choosing to keep their daughters in school. Community leaders are telling friends and neighbours to protect girls from violations of their humanity.

The rights, choices and bodies of girls—these are their own. When that principle is fully realized, in every country and community, without exception, the harm will finally, irrevocably, come to an end.

Artwork courtesy of Fatma Mahmoud Salama Raslan

Indicators

Monitoring ICPD goals: health

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Contraceptive prevalence rate, women aged 15–49				Unmet need for family planning, women aged 15–49		Proportion of demand satisfied with modern methods, women aged 15–49	Decision making on sexual and reproductive health and reproductive rights, per cent	Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent
					ANY METHOD		MODERN METHOD						
					All	Married or in union	All	Married or in union	All	Married or in union	All		
World and regional areas	2017	2017	2017	2014–2019	2020		2020		2020		2020	2020	2019
World	**211**	**199**	**243**	**81**	**49**	**63**	**45**	**57**	**9**	**11**	**77**	**55**	**73**
More developed regions	12	11	13	99	59	71	53	62	7	9	80	–	84
Less developed regions	232	219	268	79	47	62	43	56	9	12	76	54	69
Least developed countries	415	396	477	61	32	42	28	37	16	20	59	50	71
UNFPA regions													
Arab States	151	121	208	90	34	53	29	45	10	16	65	–	53
Asia and the Pacific	120	108	140	85	52	67	48	62	7	9	80	59	72
Eastern Europe and Central Asia	20	18	22	99	46	64	36	48	8	12	66	75	82
Latin America and the Caribbean	74	70	80	94	59	75	55	70	8	10	83	74	66
East and Southern Africa	391	361	463	64	34	42	31	38	16	21	62	53	75
West and Central Africa	717	606	917	55	20	21	17	18	17	22	45	37	70
Countries, territories, other areas	2017	2017	2017	2014–2019	2020		2020		2020		2020	2007–2018	2019
Afghanistan	638	427	1010	59	18	25	16	22	17	24	46	–	54
Albania	15	8	26	–	30	43	4	5	12	17	9	69	82
Algeria	112	64	206	–	35	64	31	56	6	9	76	–	–
Angola	241	167	346	47	16	16	15	15	27	36	34	62	66
Antigua and Barbuda	42	24	69	100	45	63	42	61	10	13	78	–	–
Argentina	39	35	43	94	59	71	57	67	9	11	84	–	–
Armenia	26	21	32	100	39	59	20	31	8	12	43	66	87
Aruba	–	–	–	–	–	–	–	–	–	–	–	–	–
Australia	6	5	8	97	58	67	56	64	8	11	85	–	–
Austria	5	4	7	98	64	70	62	68	6	8	88	–	–
Azerbaijan	26	21	32	99	36	56	14	22	9	14	31	–	–
Bahamas	70	48	110	99	45	67	43	65	9	12	79	–	–
Bahrain	14	10	21	100	31	67	22	45	5	11	59	–	–
Bangladesh	173	131	234	53	54	65	48	57	9	11	75	–	–
Barbados	27	17	39	99	50	63	47	60	12	15	75	–	44
Belarus	2	1	4	100	60	70	52	58	6	8	78	–	87
Belgium	5	4	7	–	59	67	59	66	6	8	90	–	–
Belize	36	26	48	94	44	56	41	53	14	18	71	–	42
Benin	397	291	570	78	16	18	13	14	25	31	32	36	91
Bhutan	183	127	292	96	38	60	37	58	9	13	79	–	–
Bolivia (Plurinational State of)	155	113	213	72	47	67	35	48	12	16	58	–	–
Bosnia and Herzegovina	10	5	16	100	37	48	18	20	11	14	37	–	–
Botswana	144	124	170	100	56	69	56	68	8	11	86	–	–
Brazil	60	58	61	99	65	80	63	77	6	8	89	–	–
Brunei Darussalam	31	21	45	100	–	–	–	–	–	–	–	–	–
Bulgaria	10	6	14	100	65	79	50	56	5	7	70	–	–
Burkina Faso	320	220	454	80	29	33	28	32	20	24	57	20	72
Burundi	548	413	728	85	19	30	16	26	18	29	45	44	64
Cambodia	160	116	221	89	42	62	31	45	8	11	62	76	98

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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					ANY METHOD		MODERN METHOD						
					All	Married or in union	All	Married or in union	All	Married or in union	All		
	2017	2017	2017	2014–2019	2020		2020		2020		2020	2007–2018	2019
Cameroon, Republic of	529	376	790	69	26	22	21	17	16	23	50	38	–
Canada	10	8	14	98	74	82	70	77	3	5	91	–	–
Cape Verde	58	45	75	92	48	67	47	65	11	12	79	–	–
Central African Republic	829	463	1470	–	23	26	17	19	18	22	41	–	77
Chad	1140	847	1590	24	7	7	6	7	18	24	24	27	75
Chile	13	11	14	100	63	77	58	71	6	8	85	–	–
China	29	22	35	100	69	85	67	83	5	4	91	–	–
China, Hong Kong SAR	–	–	–	–	48	70	45	67	8	9	80	–	–
China, Macao SAR	–	–	–	–	–	–	–	–	–	–	–	–	–
Colombia	83	71	98	99	64	82	60	77	6	7	87	–	97
Comoros	273	167	435	–	19	26	15	21	20	30	40	21	–
Congo, Democratic Republic of the	473	341	693	80	22	24	12	11	21	26	27	31	–
Congo, Republic of the	378	271	523	91	42	43	28	26	15	19	48	27	53
Costa Rica	27	24	31	99	54	73	53	71	9	11	84	–	62
Côte d'Ivoire	617	426	896	74	26	25	22	21	21	27	48	25	63
Croatia	8	6	11	100	51	71	36	46	7	8	61	–	–
Cuba	36	33	40	100	70	75	69	74	7	8	89	–	–
Curaçao	–	–	–	–	–	–	–	–	–	–	–	–	–
Cyprus	6	4	10	98	–	–	–	–	–	–	–	–	–
Czechia	3	2	5	100	63	85	56	76	3	4	84	–	70
Denmark	4	3	5	95	65	77	61	73	5	7	88	–	90
Djibouti	248	116	527	–	16	28	15	27	15	27	49	–	–
Dominica	–	–	–	100	–	–	–	–	–	–	–	–	–
Dominican Republic	95	88	102	100	57	72	55	70	9	11	84	77	–
Ecuador	59	53	65	96	59	81	53	73	6	6	82	87	–
Egypt	37	27	47	92	44	61	42	59	9	12	80	–	44
El Salvador	46	36	57	100	51	73	49	69	8	10	81	–	83
Equatorial Guinea	301	181	504	–	17	17	15	14	23	32	36	–	–
Eritrea	480	327	718	–	9	13	8	12	18	29	31	–	–
Estonia	9	5	13	99	57	65	52	57	7	12	80	–	–
Eswatini	437	255	792	–	54	68	53	66	10	13	83	49	–
Ethiopia	401	298	573	28	28	40	28	40	15	21	65	45	–
Fiji	34	27	43	100	35	51	30	44	12	16	64	–	–
Finland	3	2	4	100	79	82	74	77	3	5	90	–	98
France	8	6	9	98	65	78	63	75	4	4	91	–	–
French Guiana	–	–	–	–	–	–	–	–	–	–	–	–	–
French Polynesia	–	–	–	–	–	–	–	–	–	–	–	–	–
Gabon	252	165	407	–	37	37	29	26	19	24	52	48	58
Gambia	597	440	808	–	11	15	11	14	17	25	37	40	83
Georgia	25	21	29	99	32	46	23	33	13	19	51	–	93
Germany	7	5	9	99	61	78	60	78	5	5	91	–	–
Ghana	308	223	420	78	27	35	23	30	19	27	50	52	–

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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					ANY METHOD		MODERN METHOD						
					All	Married or in union	All	Married or in union	All	Married or in union	All		
	2017	2017	2017	2014–2019	2020		2020		2020		2020	2007–2018	2019
Greece	3	2	4	100	54	74	38	50	6	7	64	–	54
Grenada	25	15	39	100	44	63	41	59	10	13	76	–	–
Guadeloupe	–	–	–	–	45	59	41	53	11	15	72	–	–
Guam	–	–	–	–	41	66	36	55	7	11	74	–	–
Guatemala	95	86	104	70	42	63	35	53	9	13	70	65	–
Guinea	576	437	779	55	12	9	10	8	20	25	32	29	–
Guinea-Bissau	667	457	995	45	29	19	27	19	16	20	60	–	70
Guyana	169	132	215	96	33	45	32	43	17	26	62	71	75
Haiti	480	346	680	42	27	37	25	34	24	35	49	59	65
Honduras	65	55	76	74	52	75	46	67	7	9	78	70	–
Hungary	12	9	16	100	49	70	44	63	6	9	80	–	–
Iceland	4	2	6	98	–	–	–	–	–	–	–	–	–
India	145	117	177	81	43	57	38	50	9	12	74	–	–
Indonesia	177	127	254	95	44	62	42	59	8	11	81	–	–
Iran (Islamic Republic of)	16	13	20	99	58	81	46	64	4	5	75	–	–
Iraq	79	53	113	96	37	56	26	39	9	13	57	–	39
Ireland	5	3	7	100	66	70	63	66	6	9	88	–	–
Israel	3	2	4	–	39	74	31	56	5	8	68	–	–
Italy	2	1	2	100	59	66	48	51	7	9	72	–	–
Jamaica	80	67	98	100	41	67	39	64	9	11	78	–	–
Japan	5	3	6	100	47	55	40	43	12	16	67	–	83
Jordan	46	31	65	100	30	53	21	38	8	14	56	61	–
Kazakhstan	10	8	12	100	42	53	40	50	11	15	75	–	63
Kenya	342	253	476	62	46	63	45	62	12	15	77	56	–
Kiribati	92	49	158	–	19	26	16	21	18	26	44	–	–
Korea, Democratic People's Republic of	89	38	203	100	58	74	55	71	8	9	84	–	83
Korea, Republic of	11	9	13	100	56	81	51	73	6	5	82	–	–
Kuwait	12	8	17	100	41	59	34	49	10	14	67	–	–
Kyrgyzstan	60	50	76	100	29	41	27	38	13	18	65	77	73
Lao People's Democratic Republic	185	139	253	64	38	60	34	54	8	12	74	–	96
Latvia	19	15	26	100	61	72	54	62	6	9	81	–	70
Lebanon	29	22	40	–	29	62	21	45	6	13	61	–	–
Lesotho	544	391	788	87	52	65	51	64	11	15	81	61	–
Liberia	661	481	943	–	27	29	26	28	25	28	50	67	–
Libya	72	30	164	–	25	38	16	24	17	26	37	–	33
Lithuania	8	5	12	100	46	66	37	53	8	11	70	–	88
Luxembourg	5	3	8	–	–	–	–	–	–	–	–	–	–
Madagascar	335	229	484	46	40	49	35	43	15	16	64	74	–
Malawi	349	244	507	90	48	64	47	63	13	16	77	47	76
Malaysia	29	24	36	100	34	57	24	40	9	15	56	–	81
Maldives	53	35	84	100	15	21	12	16	22	30	32	58	45
Mali	562	419	784	67	17	19	17	18	21	24	44	8	79

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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					ANY METHOD		MODERN METHOD						
					All	Married or in union	All	Married or in union	All	Married or in union	All		
Malta	6	4	11	100	63	85	49	66	4	3	73	–	90
Martinique	–	–	–	–	47	62	43	56	11	14	74	–	–
Mauritania	766	528	1140	69	11	17	10	15	18	29	34	–	62
Mauritius	61	46	85	100	43	66	28	42	8	10	55	–	73
Mexico	33	32	35	96	55	73	53	70	10	10	81	–	–
Micronesia (Federated States of)	88	40	193	–	–	–	–	–	–	–	–	–	–
Moldova, Republic of	19	15	24	100	53	64	41	49	9	12	66	–	–
Mongolia	45	36	56	99	41	56	37	50	13	16	69	63	–
Montenegro	6	3	10	99	26	25	18	15	17	22	43	–	52
Morocco	70	54	91	87	42	70	36	60	7	11	73	–	–
Mozambique	289	206	418	73	25	27	24	26	19	23	55	49	94
Myanmar	250	182	351	60	33	57	32	55	8	14	78	67	82
Namibia	195	144	281	–	52	61	51	60	10	15	83	71	96
Nepal	186	135	267	58	43	54	37	47	17	22	62	48	48
Netherlands	5	4	7	–	63	73	61	71	6	7	89	–	98
New Caledonia	–	–	–	–	–	–	–	–	–	–	–	–	–
New Zealand	9	7	11	97	65	80	61	75	5	5	88	–	94
Nicaragua	98	77	127	96	53	82	51	79	5	6	88	–	–
Niger	509	368	724	39	16	18	15	17	15	18	48	7	–
Nigeria	917	658	1320	43	17	19	13	14	15	19	40	46	–
North Macedonia	7	5	10	100	40	48	21	20	13	17	39	–	–
Norway	2	2	3	99	67	86	63	79	4	4	89	–	–
Oman	19	16	22	99	20	34	14	23	15	26	39	–	–
Pakistan	140	85	229	69	24	36	18	27	12	17	51	40	65
Palestine[1]	–	–	–	100	40	61	31	47	8	11	64	–	60
Panama	52	45	59	93	47	60	45	56	14	17	73	79	–
Papua New Guinea	145	67	318	56	27	38	23	31	18	25	50	–	–
Paraguay	84	72	96	98	58	72	54	66	9	9	81	–	–
Peru	88	69	110	92	55	76	41	56	5	7	69	–	–
Philippines	121	91	168	84	35	56	26	42	10	16	58	81	75
Poland	2	2	3	100	53	73	42	56	6	8	72	–	–
Portugal	8	6	11	99	61	75	52	65	7	7	78	–	–
Puerto Rico	21	16	29	–	57	82	52	74	6	5	82	–	–
Qatar	9	6	14	100	30	47	25	40	10	16	63	–	–
Réunion	–	–	–	–	49	72	47	70	9	9	83	–	–
Romania	19	14	25	97	55	72	45	57	5	8	74	–	–
Russian Federation	17	13	23	100	49	68	41	57	7	10	75	–	–
Rwanda	248	184	347	91	33	57	30	52	12	17	68	70	–
Saint Kitts and Nevis	–	–	–	100	–	–	–	–	–	–	–	–	–
Saint Lucia	117	71	197	100	48	61	45	57	12	15	75	–	–
Saint Vincent and the Grenadines	68	44	100	99	50	66	47	64	10	12	80	–	81
Samoa	43	20	97	83	17	29	16	27	24	42	38	–	–

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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San Marino	–	–	–	–	–	–	–	–	–	–	–	–	–
São Tomé and Principe	130	73	217	93	35	45	33	42	21	28	58	46	54
Saudi Arabia	17	10	30	99	18	29	15	23	16	26	44	–	–
Senegal	315	237	434	74	22	30	21	28	16	22	55	7	–
Serbia	12	9	17	98	49	56	32	29	10	13	55	–	86
Seychelles	53	26	109	–	–	–	–	–	–	–	–	–	–
Sierra Leone	1120	808	1620	87	27	24	26	24	20	24	56	40	65
Singapore	8	5	13	100	40	69	35	60	6	10	77	–	–
Sint Maarten	–	–	–	–	–	–	–	–	–	–	–	–	–
Slovakia	5	4	7	98	56	79	47	66	4	6	79	–	–
Slovenia	7	5	9	–	54	80	45	66	6	5	76	–	–
Solomon Islands	104	70	157	86	24	32	20	27	13	17	54	–	–
Somalia	829	385	1590	–	16	27	7	10	16	27	21	–	–
South Africa	119	96	153	97	50	57	50	57	11	14	81	65	95
South Sudan	1150	789	1710	–	6	7	5	7	20	30	20	–	16
Spain	4	3	5	–	60	63	58	62	9	13	84	–	–
Sri Lanka	36	31	41	100	45	67	37	55	5	7	73	–	89
Sudan	295	207	408	78	10	15	9	14	18	28	33	–	57
Suriname	120	96	144	98	33	45	32	45	15	23	67	–	45
Sweden	4	3	6	–	62	73	57	66	6	9	83	–	100
Switzerland	5	3	7	–	72	73	68	68	4	7	89	–	92
Syrian Arab Republic	31	20	50	–	37	61	27	45	8	13	61	–	77
Tajikistan	17	10	26	95	23	31	21	29	16	22	54	33	–
Tanzania, United Republic of	524	399	712	64	36	43	31	38	16	20	60	47	–
Thailand	37	32	44	99	56	80	54	78	4	5	91	–	–
Timor-Leste, Democratic Republic of	142	102	192	57	18	30	16	28	14	24	51	40	–
Togo	396	270	557	69	24	26	22	23	23	31	46	30	73
Tonga	52	24	116	–	20	37	17	31	13	25	51	–	–
Trinidad and Tobago	67	50	90	100	40	48	35	44	15	20	65	–	32
Tunisia	43	33	54	100	30	58	26	50	8	13	69	–	–
Turkey	17	14	20	98	48	71	33	49	7	10	60	–	–
Turkmenistan	7	5	10	100	36	54	34	51	10	15	74	–	–
Turks and Caicos Islands	–	–	–	–	–	–	–	–	–	–	–	–	–
Tuvalu	–	–	–	–	–	–	–	–	–	–	–	–	–
Uganda	375	278	523	74	34	43	31	39	19	26	58	62	–
Ukraine	19	14	26	100	53	68	44	54	6	9	74	81	88
United Arab Emirates	3	2	5	100	35	50	28	40	12	17	60	–	–
United Kingdom	7	6	8	–	74	82	67	74	4	5	87	–	92
United States of America	19	17	21	99	64	76	57	66	5	6	83	–	–
United States Virgin Islands	–	–	–	–	52	75	48	70	8	8	81	–	–
Uruguay	17	14	21	100	57	79	55	77	6	7	87	–	99
Uzbekistan	29	23	37	100	49	69	46	65	6	9	83	–	–

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Countries, territories, other areas	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Contraceptive prevalence rate, women aged 15–49				Unmet need for family planning, women aged 15–49		Proportion of demand satisfied with modern methods, women aged 15–49	Decision making on sexual and reproductive health and reproductive rights, per cent	Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent
					ANY METHOD		MODERN METHOD						
					All	Married or in union	All	Married or in union	All	Married or in union	All		
	2017	2017	2017	2014–2019	2020		2020		2020		2020	2007–2018	2019
Vanuatu	–	–	–	–	36	48	31	40	15	20	60	–	–
Venezuela (Bolivarian Republic of)	125	97	170	99	56	76	52	71	8	10	82	–	–
Viet Nam	43	32	61	94	59	80	50	67	4	5	79	–	54
Western Sahara	–	–	–	–	–	–	–	–	–	–	–	–	–
Yemen	164	109	235	–	26	41	20	31	15	25	47	–	63
Zambia	213	159	289	63	36	52	35	49	15	19	67	47	91
Zimbabwe	458	360	577	86	49	69	49	68	8	10	85	60	–

NOTES

– Data not available.

a The MMR has been rounded according to the following scheme: <100, rounded to nearest 1; 100-999, rounded to nearest 1; and ≥1000, rounded to nearest 10.

1 On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine "non-member observer State status in the United Nations..."

DEFINITIONS OF THE INDICATORS

Maternal mortality ratio: Number of maternal deaths during a given time period per 100,000 live births during the same time period. (SDG indicator 3.1.1)

Births attended by skilled health personnel: Percentage of births attended by skilled heath personnel (doctor, nurse or midwife). (SDG indicator 3.1.2)

Contraceptive prevalence rate: Percentage of women aged 15 to 49 who are currently using any method of contraception.

Contraceptive prevalence rate, modern method: Percentage of women aged 15 to 49 who are currently using any modern method of contraception.

Unmet need for family planning: Percentage of women aged 15 to 49 who want to stop or delay childbearing but are not using a method of contraception.

Proportion of demand satisfied with modern methods: Percentage of total demand for family planning among women aged 15 to 49 that is satisfied by the use of modern contraception. (SDG indicator 3.7.1)

Decision making on sexual and reproductive health and reproductive rights: Percentage of women aged 15 to 49 years who are married (or in union), who make their own decisions on three areas – their health care, use of contraception, and sexual intercourse with their partners. (SDG indicator 5.6.1)

Laws and regulations that guarantee access to sexual and reproductive health care, information and education: The extent to which countries have national laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education. (SDG indicator 5.6.2)

MAIN DATA SOURCES

Maternal mortality ratio: United Nations Maternal Mortality Estimation Inter-agency Group (WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division).

Births attended by skilled health personnel: Joint global database on skilled attendance at birth, 2020, United Nations Children's Fund (UNICEF) and World Health Organization (WHO). Regional aggregates calculated by UNFPA based on data from the joint global database.

Contraceptive prevalence rate: United Nations Population Division.

Contraceptive prevalence rate, modern method: United Nations Population Division.

Unmet need for family planning: United Nations Population Division.

Proportion of demand satisfied with modern methods: United Nations Population Division.

Decision making on sexual and reproductive health and reproductive rights: UNFPA.

Laws and regulations that guarantee access to sexual and reproductive health care, information and education: UNFPA.

Monitoring ICPD goals: dignity and human rights

ADOLESCENTS AND YOUTH

World and regional areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among girls aged 15–19, per cent	Adjusted net enrolment rate, primary education, per cent, 2018		Gender parity index, primary education	Net enrolment rate, secondary education, per cent, 2018		Gender parity index, secondary education
	2020	2019	2019	male	female	2018	male	female	2018
World	**41**	**20**	–	**91**	**89**	**0.98**	**66**	**66**	**1.00**
More developed regions	12	–	–	96	96	1.00	90	91	1.01
Less developed regions	45	27	–	91	89	0.97	63	63	1.00
Least developed countries	91	38	–	83	79	0.95	40	36	0.89
UNFPA regions									
Arab States	48	20	55	85[b]	83[b]	0.97[b]	64	59	0.93
Asia and the Pacific	23	26	–	95	93	0.99	68	69	1.02
Eastern Europe and Central Asia	27	12	–	95	95	1.00	88	87	0.98
Latin America and the Caribbean	61	25	–	95	95	1.01	76	79	1.04
East and Southern Africa	95	32	24	85	83	0.98	34	32	0.95
West and Central Africa	108	39	23	79	70	0.89	42	37	0.88
Countries, territories, other areas	2003–2018	2005–2019	2004–2018	2009–2019		2009–2019	2009–2019		2009–2019
Afghanistan	62	28	–	–	–	–	63	37	0.58
Albania	16	12	–	94	97	1.03	84	89	1.06
Algeria	10	3	–	–	–	–	–	–	–
Angola	163	30	–	92	71	0.78	13	10	0.80
Antigua and Barbuda	28	–	–	96	99	1.02	88	90	1.02
Argentina	54	–	–	–	–	–	89	93	1.05
Armenia	21	5	–	91	91	1.00	87	88	1.01
Aruba	26	–	–	94	98	1.04	73	81	1.10
Australia	10	–	–	96	97	1.01	92	93	1.01
Austria	7	–	–	88	90	1.02	87	87	1.00
Azerbaijan	45	11	–	93	92	1.00	89	88	0.99
Bahamas	29	–	–	73	75	1.03	60	65	1.09
Bahrain	14	–	–	99	97	0.98	87	94	1.08
Bangladesh	74	59	–	–	–	–	61	72	1.18
Barbados	50	29	–	99	98	0.98	91	97	1.07
Belarus	14	5	–	95	95	1.00	95	96	1.01
Belgium	6	–	–	99	99	1.00	95	95	1.00
Belize	64	34	–	99	99	1.00	69	73	1.06
Benin	108	31	2	–	–	–	53	40	0.75
Bhutan	28	26	–	89	91	1.02	64	77	1.19
Bolivia (Plurinational State of)	71	20	–	93	93	1.00	76	77	1.01
Bosnia and Herzegovina	11	4	–	–	–	–	–	–	–
Botswana	50	–	–	87	89	1.02	–	–	–
Brazil	53	26	–	97	97	1.00	80	83	1.04
Brunei Darussalam	10	–	–	–	–	–	81	84	1.03
Bulgaria	38	–	–	88	88	1.00	90	88	0.97
Burkina Faso	132	52	58	80	78	0.98	30	32	1.04
Burundi	58	19	–	92	95	1.03	24	31	1.29
Cambodia	57	19	–	91	91	1.00	–	–	–
Cameroon, Republic of	119	31	0.4	97	89	0.91	49	43	0.88
Canada	8	–	–	–	–	–	100	100	1.00

ADOLESCENTS AND YOUTH

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among girls aged 15–19, per cent	Adjusted net enrolment rate, primary education, per cent, 2018		Gender parity index, primary education	Net enrolment rate, secondary education, per cent, 2018		Gender parity index, secondary education
	2003–2018	2005–2019	2004–2018	male	female	2009–2019	male	female	2009–2019
Cape Verde	80	18	–	94	93	0.98	66	74	1.12
Central African Republic	229	68	18	72	56	0.77	16	10	0.62
Chad	179	67	32	83	64	0.78	25	12	0.48
Chile	26	–	–	95	95	1.00	87	90	1.03
China	9	–	–	–	–	–	–	–	–
China, Hong Kong SAR	2	–	–	–	–	–	96	97	1.01
China, Macao SAR	3	–	–	96	96	1.00	85	88	1.05
Colombia	61	23	–	97	98	1.01	75	80	1.07
Comoros	70	32	–	82	82	1.00	49	52	1.05
Congo, Democratic Republic of the	138	37	–	–	–	–	–	–	–
Congo, Republic of the	111	27	–	85	93	1.09	–	–	–
Costa Rica	50	21	–	97	97	1.00	81	84	1.05
Côte d'Ivoire	123	27	27	98	90	0.92	45	35	0.77
Croatia	9	–	–	96	98	1.02	91	94	1.04
Cuba	52	26	–	98	98	1.00	82	87	1.06
Curaçao	23	–	–	–	–	–	–	–	–
Cyprus	4	–	–	97	98	1.01	95	95	1.00
Czechia	12	–	–	87	89	1.03	90	91	1.02
Denmark	3	–	–	98	99	1.01	90	92	1.03
Djibouti	21	5	80	67	67	1.00	38	37	0.97
Dominica	48	–	–	90	93	1.04	84	91	1.08
Dominican Republic	51	36	–	94	94	1.00	67	75	1.12
Ecuador	71	20	–	–	–	–	83	86	1.03
Egypt	52	17	70	98	99	1.00	82	83	1.01
El Salvador	74	26	–	81	82	1.01	61	63	1.02
Equatorial Guinea	176	30	–	44	45	1.02	–	–	–
Eritrea	76	41	69	54	49	0.91	43	40	0.94
Estonia	11	–	–	93	95	1.01	93	95	1.02
Eswatini	87	5	–	83	82	1.00	36	47	1.30
Ethiopia	80	40	47	88	82	0.93	31	30	0.97
Fiji	23	–	–	99	99	0.99	80	89	1.10
Finland	5	–	–	99	99	1.00	96	96	1.01
France	9	–	–	99	100	1.01	94	95	1.01
French Guiana	76	–	–	–	–	–	–	–	–
French Polynesia	42	–	–	–	–	–	–	–	–
Gabon	91	22	–	–	–	–	–	–	–
Gambia	86	26	75	78	86	1.10	–	–	–
Georgia	32	14	–	98	98	1.01	95	97	1.02
Germany	6	–	–	90	92	1.02	86	85	0.99
Ghana	75	21	2	86	87	1.01	57	58	1.02
Greece	9	–	–	98	98	1.00	94	93	0.98
Grenada	36	–	–	–	–	–	93	83	0.89
Guadeloupe	16	–	–	–	–	–	–	–	–
Guam	35	–	–	–	–	–	–	–	–

ADOLESCENTS AND YOUTH

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among girls aged 15–19, per cent	Adjusted net enrolment rate, primary education, per cent, 2018		Gender parity index, primary education	Net enrolment rate, secondary education, per cent, 2018		Gender parity index, secondary education
	2003–2018	2005–2019	2004–2018	male	female	2009–2019	male	female	2009–2019
Guatemala	79	30	–	89	90	1.01	45	43	0.96
Guinea	120	47	92	85	71	0.83	39	26	0.66
Guinea-Bissau	106	24	42	75	71	0.95	–	–	–
Guyana	74	30	–	97	94	0.97	80	84	1.05
Haiti	55	15	–	–	–	–	–	–	–
Honduras	89	34	–	80	81	1.02	41	47	1.14
Hungary	23	–	–	96	97	1.00	89	90	1.01
Iceland	6	–	–	100	99	1.00	90	92	1.02
India	11	27	–	97	99	1.02	61	62	1.02
Indonesia	36	16	–	97	92	0.95	78	80	1.03
Iran (Islamic Republic of)	33	17	–	98	98	0.99	82	80	0.98
Iraq	82	28	4	–	–	–	–	–	–
Ireland	7	–	–	–	–	–	97	99	1.01
Israel	10	–	–	–	–	–	98	100	1.02
Italy	4	–	–	97	97	1.00	94	95	1.01
Jamaica	52	8	–	81	82	1.01	72	76	1.06
Japan	3	–	–	–	–	–	–	–	–
Jordan	27	10	–	82	80	0.98	62	64	1.03
Kazakhstan	26	7	–	–	–	–	93	93	1.01
Kenya	96	23	11	79	83	1.04	49	46	0.93
Kiribati	49	20	–	–	–	–	–	–	–
Korea, Democratic People's Republic of	1	–	–	98	98	1.00	–	–	–
Korea, Republic of	1	–	–	98	98	1.00	98	98	1.00
Kuwait	6	–	–	84	93	1.11	85	89	1.05
Kyrgyzstan	34	13	–	98	97	0.99	85	84	0.99
Lao People's Democratic Republic	83	33	–	92	91	0.98	61	59	0.98
Latvia	16	–	–	96	98	1.01	93	95	1.02
Lebanon	13	6	–	–	–	–	–	–	–
Lesotho	94	16	–	90	92	1.02	33	50	1.53
Liberia[a]	150	36	26	44	45	1.01	17	15	0.87
Libya	11	–	–	–	–	–	–	–	–
Lithuania	13	–	–	–	–	–	98	98	1.00
Luxembourg	4	–	–	98	98	1.01	82	85	1.04
Madagascar	152	40	–	–	–	–	29	31	1.08
Malawi	138	42	–	–	–	–	34	35	1.03
Malaysia	9	–	–	100	100	1.00	69	75	1.09
Maldives	9	2	1	94	96	1.02	–	–	–
Mali	164	54	86	62	56	0.90	33	27	0.81
Malta	13	–	–	–	–	–	92	94	1.03
Martinique	17	–	–	–	–	–	–	–	–
Mauritania	84	37	63	79	81	1.03	30	32	1.05
Mauritius	24	–	–	95	97	1.02	82	87	1.07
Mexico	71	26	–	–	–	–	80	83	1.03
Micronesia (Federated States of)	44	–	–	85	86	1.00	–	–	–
Moldova, Republic of	21	12	–	90	90	1.01	78	78	0.99

ADOLESCENTS AND YOUTH

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among girls aged 15–19, per cent	Adjusted net enrolment rate, primary education, per cent, 2018		Gender parity index, primary education	Net enrolment rate, secondary education, per cent, 2018		Gender parity index, secondary education
	2003–2018	2005–2019	2004–2018	male	female	2009–2019	male	female	2009–2019
Mongolia	33	12	–	97	96	0.99	–	–	–
Montenegro	10	6	–	96	97	1.01	88	90	1.01
Morocco	19	14	–	97	97	1.00	64	64	1.00
Mozambique	180	53	–	95	92	0.97	19	19	1.00
Myanmar	28	16	–	90	88	0.99	61	67	1.08
Namibia	64	7	–	95	98	1.03	–	–	–
Nepal	88	40	–	–	–	–	61	63	1.03
Netherlands	3	–	–	99	99	1.01	93	94	1.01
New Caledonia	15	–	–	–	–	–	–	–	–
New Zealand	14	–	–	98	99	1.01	96	98	1.02
Nicaragua	92	35	–	95	98	1.03	45	52	1.17
Niger	154	76	1	69	58	0.85	23	17	0.74
Nigeria	106	43	14	72	60	0.84	–	–	–
North Macedonia	15	7	–	96	96	1.00	–	–	–
Norway	3	–	–	100	100	1.00	96	96	1.00
Oman	12	4	–	98	100	1.02	99	93	0.94
Pakistan	46	18	–	74	62	0.84	40	34	0.85
Palestine[1]	48	15	–	97	97	1.00	83	91	1.09
Panama	76	26	–	87	86	0.99	62	66	1.07
Papua New Guinea	68	27	–	78	73	0.93	35	29	0.82
Paraguay	72	22	–	88	88	1.00	66	66	1.00
Peru	44	17	–	96	97	1.01	91	88	0.96
Philippines	39	17	–	95	95	1.00	60	71	1.19
Poland	11	–	–	97	97	1.00	94	94	1.00
Portugal	8	–	–	98	97	0.99	94	95	1.01
Puerto Rico	22	–	–	77	80	1.04	73	79	1.09
Qatar	9	4	–	97	99	1.03	96	92	0.96
Réunion	30	–	–	–	–	–	–	–	–
Romania	38	–	–	86	86	1.00	82	83	1.01
Russian Federation	22	–	–	97	98	1.01	90	91	1.01
Rwanda	41	7	–	95	96	1.01	33	39	1.18
Saint Kitts and Nevis	46	–	–	–	–	–	96	100	1.04
Saint Lucia	36	24	–	97	100	1.03	81	82	1.01
Saint Vincent and the Grenadines	52	–	–	–	–	–	87	92	1.05
Samoa	39	11	–	–	–	–	82	90	1.10
San Marino	1	–	–	–	–	–	70	63	0.89
São Tomé and Principe	92	35	–	94	94	1.00	62	69	1.12
Saudi Arabia	9	–	–	95	95	1.00	99	94	0.96
Senegal	78	29	21	72	81	1.12	36	39	1.10
Serbia	15	3	–	98	98	1.00	92	93	1.01
Seychelles	68	–	–	–	–	–	78	83	1.06
Sierra Leone	101	30	64	98	98	1.00	43	41	0.96
Singapore	3	–	–	–	–	–	100	100	1.00
Sint Maarten	–	–	–	–	–	–	68	72	1.06
Slovakia	27	–	–	82	84	1.02	84	85	1.01

ADOLESCENTS AND YOUTH

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19 2003–2018	Child marriage by age 18, per cent 2005–2019	Female genital mutilation prevalence among girls aged 15–19, per cent 2004–2018	Adjusted net enrolment rate, primary education, per cent, 2018 male	Adjusted net enrolment rate, primary education, per cent, 2018 female	Gender parity index, primary education 2009–2019	Net enrolment rate, secondary education, per cent, 2018 male	Net enrolment rate, secondary education, per cent, 2018 female	Gender parity index, secondary education 2009–2019
Slovenia	4	–	–	98	99	1.01	95	97	1.02
Solomon Islands	78	21	–	67	68	1.01	–	–	–
Somalia	123	45	97	–	–	–	–	–	–
South Africa	41	4	–	90	95	1.05	65	79	1.20
South Sudan	158	52	–	40	30	0.76	6	4	0.70
Spain	7	–	–	97	98	1.01	96	98	1.02
Sri Lanka	21	10	–	98	97	0.98	90	92	1.03
Sudan	87	34	82	62	61	0.98	32	31	0.95
Suriname	57	36	–	84	88	1.04	52	64	1.23
Sweden	5	–	–	–	–	–	100	99	1.00
Switzerland	2	–	–	99	100	1.01	87	84	0.97
Syrian Arab Republic	54	13	–	73	71	0.98	49	48	0.98
Tajikistan	54	9	–	98	97	0.99	87	79	0.90
Tanzania, United Republic of	139	31	5	81	84	1.04	26	27	1.06
Thailand	38	23	–	98	98	1.00	77	78	1.01
Timor-Leste, Democratic Republic of	42	15	–	94	97	1.03	59	67	1.14
Togo	89	25	1	97	92	0.95	49	33	0.69
Tonga	30	6	–	–	–	–	81	84	1.04
Trinidad and Tobago	38	11	–	99	98	0.99	–	–	–
Tunisia	4	2	–	97	100	1.02	–	–	–
Turkey	21	15	–	95	95	0.99	88	86	0.97
Turkmenistan	28	6	–	–	–	–	–	–	–
Turks and Caicos Islands	15	–	–	–	–	–	–	–	–
Tuvalu	27	10	–	91	84	0.92	62	71	1.14
Uganda	132	34	0.1	94	97	1.03	–	–	–
Ukraine	19	9	–	91	93	1.02	85	86	1.01
United Arab Emirates	5	–	–	92	95	1.03	95	90	0.95
United Kingdom	12	–	–	100	99	1.00	97	97	1.00
United States of America	19	–	–	96	96	1.00	92	93	1.01
United States Virgin Islands	25	–	–	–	–	–	–	–	–
Uruguay	36	25	–	97	97	1.00	85	91	1.07
Uzbekistan	19	7	–	98	96	0.99	91	90	0.99
Vanuatu	51	21	–	92	93	1.01	48	50	1.04
Venezuela (Bolivarian Republic of)	95	–	–	90	90	1.00	70	77	1.10
Viet Nam	30	11	–	–	–	–	–	–	–
Western Sahara	–	–	–	–	–	–	–	–	–
Yemen	67	32	16	90	79	0.88	55	40	0.73
Zambia	135	29	–	83	87	1.05	–	–	–
Zimbabwe	78	34	–	–	–	–	49	49	0.99

NOTES

– Data not available.

a Percentage of girls aged 15-19 years who are members of the Sande society. Membership in Sande society is a proxy for female genital mutilation.

b Reference year is 2017.

1 On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine "non-member observer State status in the United Nations..."

DEFINITIONS OF THE INDICATORS

Adolescent birth rate: Number of births per 1,000 adolescent girls aged 15–19. (SDG indicator 3.7.2)

Child marriage by age 18: Proportion of women aged 20-24 years who were married or in a union before age 18. (SDG indicator 5.3.1)

Female genital mutilation prevalence among girls aged 15-19: Proportion of girls aged 15-19 years who have undergone female genital mutilation. (SDG indicator 5.3.2)

Adjusted net enrolment rate, primary education: Percentage of children of the official primary age group who are enrolled in primary or secondary education.

Gender parity index, primary education: Ratio of female to male values of adjusted primary school net enrolment ratio.

Net enrolment rate, secondary education: Percentage of children of the official secondary age group who are enrolled in secondary education.

Gender parity index, secondary education: Ratio of female to male values of secondary school net enrolment ratio.

MAIN DATA SOURCES

Adolescent birth rate: United Nations Population Division.

Child marriage by age 18: UNICEF. Regional aggregates calculated by UNFPA based on data from UNICEF.

Female genital mutilation prevalence among girls aged 15-19: UNFPA.

Adjusted net enrolment rate, primary education: UNESCO Institute for Statistics (UIS).

Gender parity index, primary education: UNESCO Institute for Statistics (UIS).

Net enrolment rate, secondary education: UNESCO Institute for Statistics (UIS).

Gender parity index, secondary education: UNESCO Institute for Statistics (UIS).

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION				SEX RATIO	FERTILITY	LIFE EXPECTANCY
	Total population in millions	Average annual rate of population change, per cent	Population aged 0–14, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Sex ratio at birth, per female birth	Total fertility rate, per woman	Life expectancy at birth, years
World and regional areas	2020	2015–2020	2020	2020	2020	2020	2017	2020	2020
World	**7,795**	**1.1**	**25.4**	**23.7**	**65.2**	**9.3**	**1.068**	**2.4**	**73**
More developed regions	1,273	0.3	16.4	16.6	64.3	19.3	–	1.6	80
Less developed regions	6,521	1.3	27.2	25.1	65.4	7.4	–	2.6	71
Least developed countries	1,057	2.3	38.8	31.8	57.6	3.6	–	3.9	66
UNFPA regions									
Arab States	377	1.9	34.0	27.6	61.0	5.0	–	3.3	72
Asia and the Pacific	4,083	0.9	23.6	23.5	68.0	8.4	–	2.1	73
Eastern Europe and Central Asia	250	0.9	23.4	21.2	66.3	10.2	–	2.1	74
Latin America and the Caribbean	650	1.0	23.9	24.5	67.2	8.9	–	2.0	76
East and Southern Africa	617	2.6	41.2	32.3	55.6	3.2	–	4.2	64
West and Central Africa	459	2.7	43.1	32.2	54.1	2.8	–	5.0	58
Countries, territories, other areas	2020	2015–2020	2020	2020	2020	2020	2017	2020	2020
Afghanistan	38.9	2.5	41.8	35.3	55.5	2.6	1.059	4.2	65
Albania	2.9	-0.1	17.2	20.5	68.1	14.7	1.083	1.6	79
Algeria	43.9	2.0	30.8	22.2	62.5	6.7	1.044	2.9	77
Angola	32.9	3.3	46.4	32.8	51.4	2.2	1.027	5.4	61
Antigua and Barbuda	0.1	0.9	21.8	21.9	68.8	9.3	1.031	2.0	77
Argentina	45.2	1.0	24.4	23.5	64.2	11.4	1.057	2.2	77
Armenia	3.0	0.3	20.8	18.4	67.4	11.8	1.117	1.8	75
Aruba[1]	0.1	0.5	17.4	20.2	68.0	14.6	1.045	1.9	76
Australia[2]	25.5	1.3	19.3	18.5	64.5	16.2	1.057	1.8	84
Austria	9.0	0.7	14.4	15.4	66.4	19.2	1.064	1.6	82
Azerbaijan[3]	10.1	1.0	23.5	20.3	69.7	6.7	1.134	2.0	73
Bahamas	0.4	1.0	21.6	24.7	70.6	7.7	1.029	1.7	74
Bahrain	1.7	4.3	18.3	16.1	79.1	2.7	1.041	1.9	77
Bangladesh	164.7	1.1	26.8	27.9	68.0	5.2	1.055	2.0	73
Barbados	0.3	0.1	16.8	19.2	66.5	16.7	1.037	1.6	79
Belarus	9.4	0.0	17.2	14.3	67.2	15.6	1.063	1.7	75
Belgium	11.6	0.5	17.0	17.0	63.7	19.3	1.050	1.7	82
Belize	0.4	1.9	29.2	29.5	65.8	5.0	1.050	2.2	75
Benin	12.1	2.7	41.9	32.1	54.8	3.3	1.042	4.7	62
Bhutan	0.8	1.2	24.9	27.3	68.9	6.2	1.051	1.9	72
Bolivia (Plurinational State of)	11.7	1.4	30.2	28.8	62.3	7.5	1.042	2.7	72
Bosnia and Herzegovina	3.3	-0.9	14.5	17.1	67.6	17.9	1.067	1.2	78
Botswana	2.4	2.1	33.4	28.7	62.1	4.5	1.031	2.8	70
Brazil	212.6	0.8	20.7	22.7	69.7	9.6	1.044	1.7	76
Brunei Darussalam	0.4	1.1	22.3	22.9	72.1	5.6	1.072	1.8	76
Bulgaria	6.9	-0.7	14.7	14.2	63.9	21.5	1.061	1.6	75
Burkina Faso	20.9	2.9	44.4	33.2	53.2	2.4	1.041	5.0	62
Burundi	11.9	3.1	45.3	31.7	52.4	2.4	1.023	5.2	62
Cambodia	16.7	1.5	30.9	27.7	64.2	4.9	1.052	2.5	70
Cameroon, Republic of	26.5	2.6	42.1	32.4	55.2	2.7	1.026	4.4	60
Canada	37.7	0.9	15.8	16.8	66.1	18.1	1.056	1.5	83
Cape Verde	0.6	1.2	28.1	26.2	67.1	4.8	1.033	2.2	73

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION				SEX RATIO	FERTILITY	LIFE EXPECTANCY
	Total population in millions	Average annual rate of population change, per cent	Population aged 0–14, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Sex ratio at birth, per female birth	Total fertility rate, per woman	Life expectancy at birth, years
Countries, territories, other areas	2020	2015–2020	2020	2020	2020	2020	2017	2020	2020
Central African Republic	4.8	1.4	43.5	36.2	53.7	2.8	1.031	4.6	54
Chad	16.4	3.0	46.5	33.9	51.0	2.5	1.039	5.6	55
Chile	19.1	1.2	19.2	20.4	68.5	12.2	1.043	1.6	80
China[4]	1,439.3	0.5	17.7	17.6	70.3	12.0	1.143	1.7	77
China, Hong Kong SAR[5]	7.5	0.8	12.7	12.4	69.1	18.2	1.078	1.4	85
China, Macao SAR[6]	0.6	1.5	14.4	12.8	73.7	12.0	1.084	1.2	84
Colombia	50.9	1.4	22.2	24.6	68.8	9.1	1.045	1.8	77
Comoros	0.9	2.2	39.0	31.1	57.9	3.1	1.032	4.1	65
Congo, Democratic Republic of the	89.6	3.2	45.8	32.1	51.2	3.0	1.022	5.7	61
Congo, Republic of the	5.5	2.6	41.3	31.4	56.0	2.8	1.025	4.3	65
Costa Rica	5.1	1.0	20.8	22.0	68.9	10.3	1.043	1.7	80
Côte d'Ivoire	26.4	2.5	41.5	32.8	55.6	2.9	1.030	4.5	58
Croatia	4.1	-0.6	14.5	15.7	64.2	21.3	1.058	1.4	79
Cuba	11.3	0.0	15.9	17.2	68.2	15.9	1.073	1.6	79
Curaçao[1]	0.2	0.5	18.2	18.9	64.2	17.7	1.045	1.7	79
Cyprus[7]	1.2	0.8	16.6	19.5	69.0	14.4	1.065	1.3	81
Czechia	10.7	0.2	15.8	14.3	64.1	20.1	1.055	1.7	80
Denmark[8]	5.8	0.4	16.3	18.1	63.6	20.2	1.057	1.8	81
Djibouti	1.0	1.6	28.9	27.3	66.4	4.7	1.038	2.6	67
Dominica	0.1	0.2	–	–	–	–	1.030	–	–
Dominican Republic	10.8	1.1	27.4	26.5	65.0	7.5	1.045	2.3	74
Ecuador	17.6	1.7	27.4	26.5	65.0	7.6	1.046	2.4	77
Egypt	102.3	2.0	33.9	26.2	60.7	5.3	1.054	3.2	72
El Salvador	6.5	0.5	26.6	27.7	64.8	8.7	1.064	2.0	74
Equatorial Guinea	1.4	3.7	36.8	28.8	60.8	2.4	1.031	4.3	59
Eritrea	3.5	1.2	41.1	32.3	54.4	4.5	1.031	3.9	67
Estonia	1.3	0.2	16.5	14.7	63.1	20.4	1.057	1.6	79
Eswatini	1.2	1.0	37.4	33.6	58.5	4.0	1.027	2.9	61
Ethiopia	115.0	2.6	39.9	33.6	56.5	3.5	1.055	4.0	67
Fiji	0.9	0.6	29.0	25.7	65.2	5.8	1.069	2.7	68
Finland[9]	5.5	0.2	15.9	16.6	61.6	22.6	1.051	1.5	82
France[10]	65.3	0.3	17.7	17.7	61.6	20.8	1.049	1.8	83
French Guiana[11]	0.3	2.7	31.8	27.7	62.6	5.6	1.035	3.3	80
French Polynesia[11]	0.3	0.6	22.2	23.4	68.7	9.1	1.055	1.9	78
Gabon	2.2	2.7	37.3	27.1	59.2	3.5	1.020	3.9	67
Gambia	2.4	2.9	44.0	32.5	53.5	2.5	1.031	5.1	62
Georgia[12]	4.0	-0.2	20.2	17.7	64.5	15.3	1.065	2.0	74
Germany	83.8	0.5	14.0	14.9	64.4	21.7	1.054	1.6	81
Ghana	31.1	2.2	37.1	30.5	59.7	3.1	1.040	3.8	64
Greece	10.4	-0.4	13.7	15.3	64.1	22.3	1.062	1.3	82
Grenada	0.1	0.5	23.8	22.1	66.4	9.8	1.032	2.0	72
Guadeloupe[11]	0.4	0.0	18.4	21.7	62.2	19.4	1.032	2.1	82
Guam[13]	0.2	0.8	23.9	24.3	65.6	10.5	1.073	2.3	80
Guatemala	17.9	1.9	33.3	31.7	61.6	5.0	1.039	2.8	75
Guinea	13.1	2.8	43.0	34.3	54.0	3.0	1.041	4.6	62

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION				SEX RATIO	FERTILITY	LIFE EXPECTANCY
	Total population in millions	Average annual rate of population change, per cent	Population aged 0–14, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Sex ratio at birth, per female birth	Total fertility rate, per woman	Life expectancy at birth, years
Countries, territories, other areas	2020	2015–2020	2020	2020	2020	2020	2017	2020	2020
Guinea-Bissau	2.0	2.5	41.9	32.1	55.2	2.9	1.036	4.3	59
Guyana	0.8	0.5	27.7	28.3	65.3	7.0	1.041	2.4	70
Haiti	11.4	1.3	32.5	29.9	62.4	5.2	1.031	2.8	64
Honduras	9.9	1.7	30.6	31.1	64.4	5.0	1.052	2.4	75
Hungary	9.7	-0.2	14.4	15.4	65.4	20.2	1.058	1.5	77
Iceland	0.3	0.7	19.4	19.6	65.0	15.6	1.048	1.7	83
India	1,380.0	1.0	26.2	27.2	67.3	6.6	1.098	2.2	70
Indonesia	273.5	1.1	25.9	25.2	67.8	6.3	1.060	2.3	72
Iran (Islamic Republic of)	84.0	1.4	24.7	20.6	68.7	6.6	1.052	2.1	77
Iraq	40.2	2.5	37.7	31.1	58.8	3.4	1.053	3.5	71
Ireland	4.9	1.2	20.8	19.4	64.6	14.6	1.050	1.8	82
Israel	8.7	1.6	27.8	23.4	59.8	12.4	1.058	3.0	83
Italy	60.5	0.0	13.0	14.3	63.7	23.3	1.059	1.3	84
Jamaica	3.0	0.5	23.4	24.6	67.6	9.1	1.037	2.0	75
Japan	126.5	-0.2	12.4	13.7	59.2	28.4	1.054	1.4	85
Jordan	10.2	1.9	32.9	30.6	63.2	4.0	1.051	2.6	75
Kazakhstan	18.8	1.3	29.1	20.3	63.0	7.9	1.061	2.7	74
Kenya	53.8	2.3	38.6	33.4	58.9	2.5	1.021	3.4	67
Kiribati	0.1	1.5	35.9	28.9	59.9	4.2	1.067	3.5	69
Korea, Democratic People's Republic of	25.8	0.5	19.8	21.3	70.8	9.3	1.062	1.9	72
Korea, Republic of	51.3	0.2	12.5	15.5	71.7	15.8	1.056	1.1	83
Kuwait	4.3	2.1	21.5	17.3	75.5	3.0	1.046	2.1	76
Kyrgyzstan	6.5	1.8	32.6	24.8	62.6	4.7	1.060	2.9	72
Lao People's Democratic Republic	7.3	1.5	31.9	29.7	63.8	4.3	1.054	2.6	68
Latvia	1.9	-1.1	16.4	13.7	62.9	20.7	1.059	1.7	75
Lebanon	6.8	0.9	25.1	25.3	67.4	7.5	1.052	2.1	79
Lesotho	2.1	0.8	32.2	29.5	62.8	4.9	1.027	3.1	55
Liberia	5.1	2.5	40.4	32.4	56.3	3.3	1.038	4.2	64
Libya	6.9	1.4	27.8	25.1	67.7	4.5	1.056	2.2	73
Lithuania	2.7	-1.5	15.5	13.8	63.9	20.6	1.053	1.7	76
Luxembourg	0.6	2.0	15.6	16.9	70.1	14.4	1.060	1.4	82
Madagascar	27.7	2.7	40.1	32.6	56.8	3.1	1.036	4.0	67
Malawi	19.1	2.7	43.0	34.4	54.4	2.6	1.013	4.1	65
Malaysia[14]	32.4	1.3	23.4	24.7	69.4	7.2	1.066	2.0	76
Maldives	0.5	3.4	19.6	20.4	76.8	3.6	1.066	1.8	79
Mali	20.3	3.0	47.0	33.5	50.5	2.5	1.033	5.7	60
Malta	0.4	0.4	14.4	14.9	64.3	21.3	1.067	1.5	83
Martinique[11]	0.4	-0.2	15.7	19.1	62.6	21.7	1.029	1.8	83
Mauritania	4.6	2.8	39.7	30.6	57.1	3.2	1.032	4.4	65
Mauritius[15]	1.3	0.2	16.8	21.2	70.7	12.5	1.037	1.4	75
Mexico	128.9	1.1	25.8	25.8	66.5	7.6	1.037	2.1	75
Micronesia (Federated States of)	0.1	1.1	31.2	30.4	64.4	4.4	1.067	3.0	68
Moldova, Republic of[16]	4.0	-0.2	15.9	16.4	71.6	12.5	1.062	1.3	72
Mongolia	3.3	1.8	31.1	22.2	64.6	4.3	1.051	2.8	70

Countries, territories, other areas	POPULATION Total population in millions 2020	POPULATION CHANGE Average annual rate of population change, per cent 2015–2020	POPULATION COMPOSITION Population aged 0–14, per cent 2020	 Population aged 10–24, per cent 2020	 Population aged 15–64, per cent 2020	 Population aged 65 and older, per cent 2020	SEX RATIO Sex ratio at birth, per female birth 2017	FERTILITY Total fertility rate, per woman 2020	LIFE EXPECTANCY Life expectancy at birth, years 2020
Montenegro	0.6	0.0	18.0	19.1	66.2	15.8	1.072	1.7	77
Morocco	36.9	1.3	26.8	24.3	65.6	7.6	1.069	2.4	77
Mozambique	31.3	2.9	44.1	33.6	53.1	2.9	1.018	4.7	61
Myanmar	54.4	0.6	25.5	27.0	68.3	6.2	1.066	2.1	67
Namibia	2.5	1.9	36.8	30.3	59.6	3.6	1.011	3.3	64
Nepal	29.1	1.5	28.8	32.1	65.4	5.8	1.073	1.8	71
Netherlands[17]	17.1	0.2	15.7	17.4	64.3	20.0	1.054	1.7	82
New Caledonia[11]	0.3	1.0	22.1	23.3	68.2	9.7	1.060	1.9	78
New Zealand[18]	4.8	0.9	19.4	19.7	64.2	16.4	1.056	1.9	82
Nicaragua	6.6	1.3	29.5	27.5	64.8	5.7	1.034	2.3	75
Niger	24.2	3.8	49.7	33.0	47.7	2.6	1.040	6.7	63
Nigeria	206.1	2.6	43.5	31.9	53.8	2.7	1.036	5.2	55
North Macedonia	2.1	0.0	16.3	17.5	69.2	14.5	1.073	1.5	76
Norway[19]	5.4	0.8	17.3	18.4	65.2	17.5	1.057	1.7	83
Oman	5.1	3.6	22.5	16.8	75.0	2.5	1.043	2.8	78
Pakistan	220.9	2.0	34.8	30.0	60.8	4.3	1.064	3.4	67
Palestine[20]	5.1	2.4	38.4	31.5	58.4	3.2	1.053	3.5	74
Panama	4.3	1.7	26.5	24.9	65.0	8.5	1.050	2.4	79
Papua New Guinea	8.9	2.0	35.1	30.8	61.3	3.6	1.067	3.5	65
Paraguay	7.1	1.3	28.9	28.2	64.3	6.8	1.051	2.4	74
Peru	33.0	1.6	24.7	23.5	66.6	8.7	1.040	2.2	77
Philippines	109.6	1.4	30.0	28.7	64.4	5.5	1.080	2.5	71
Poland	37.8	-0.1	15.2	15.0	66.0	18.7	1.059	1.4	79
Portugal	10.2	-0.3	13.1	15.3	64.2	22.8	1.054	1.3	82
Puerto Rico[13]	2.9	-3.3	15.8	18.8	63.4	20.8	1.057	1.2	80
Qatar	2.9	2.3	13.6	16.2	84.7	1.7	1.044	1.8	80
Réunion[11]	0.9	0.7	22.4	22.6	64.9	12.7	1.035	2.2	81
Romania	19.2	-0.7	15.5	16.0	65.2	19.2	1.061	1.6	76
Russian Federation	145.9	0.1	18.4	15.0	66.1	15.5	1.059	1.8	73
Rwanda	13.0	2.6	39.5	31.6	57.4	3.1	1.027	3.9	69
Saint Kitts and Nevis	0.1	0.8	–	–	–	–	1.037	–	–
Saint Lucia	0.2	0.5	18.0	21.9	71.8	10.3	1.036	1.4	76
Saint Vincent and the Grenadines	0.1	0.3	21.9	24.1	68.2	9.9	1.029	1.9	73
Samoa	0.2	0.5	37.2	29.5	57.7	5.1	1.067	3.8	73
San Marino	0.3	0.4	–	–	–	–	1.067	–	–
São Tomé and Principe	0.2	1.9	41.8	33.2	55.2	3.0	1.028	4.2	71
Saudi Arabia	34.8	1.9	24.7	20.7	71.8	3.5	1.050	2.2	75
Senegal	16.7	2.8	42.6	32.1	54.3	3.1	1.033	4.5	68
Serbia[21]	8.7	-0.3	15.4	17.5	65.6	19.1	1.071	1.4	76
Seychelles	0.1	0.7	23.8	20.6	68.2	8.1	1.034	2.4	73
Sierra Leone	8.0	2.1	40.3	32.9	56.7	2.9	1.032	4.1	55
Singapore	5.9	0.9	12.3	15.4	74.3	13.4	1.065	1.2	84
Sint Maarten[1]	0.04	1.4	–	–	–	–	–	–	–
Slovakia	5.5	0.1	15.6	15.3	67.7	16.7	1.055	1.5	78
Slovenia	2.1	0.1	15.1	14.1	64.1	20.7	1.059	1.6	81

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION				SEX RATIO	FERTILITY	LIFE EXPECTANCY
	Total population in millions	Average annual rate of population change, per cent	Population aged 0–14, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Sex ratio at birth, per female birth	Total fertility rate, per woman	Life expectancy at birth, years
Countries, territories, other areas	2020	2015–2020	2020	2020	2020	2020	2017	2020	2020
Solomon Islands	0.7	2.6	40.0	30.5	56.3	3.7	1.067	4.3	73
Somalia	15.9	2.8	46.1	34.4	50.9	2.9	1.043	5.9	58
South Africa	59.3	1.4	28.8	25.9	65.7	5.5	1.031	2.4	64
South Sudan	11.2	0.9	41.3	32.6	55.3	3.4	1.034	4.5	58
Spain[22]	46.8	0.0	14.4	15.0	65.6	20.0	1.065	1.4	84
Sri Lanka	21.4	0.5	23.7	22.8	65.1	11.2	1.039	2.2	77
Sudan	43.8	2.4	39.8	32.6	56.5	3.7	1.041	4.3	66
Suriname	0.6	1.0	26.7	25.7	66.2	7.1	1.031	2.4	72
Sweden	10.1	0.7	17.6	16.5	62.0	20.3	1.058	1.8	83
Switzerland	8.7	0.8	15.0	15.2	65.9	19.1	1.055	1.5	84
Syrian Arab Republic	17.5	-0.6	30.8	28.2	64.4	4.9	1.052	2.7	74
Tajikistan	9.5	2.4	37.3	27.5	59.6	3.2	1.061	3.5	71
Tanzania, United Republic of[23]	59.7	3.0	43.6	32.4	53.8	2.6	1.027	4.8	66
Thailand	69.8	0.3	16.6	19.1	70.5	13.0	1.064	1.5	77
Timor-Leste, Democratic Republic of	1.3	1.9	36.8	33.1	58.9	4.3	1.070	3.9	70
Togo	8.3	2.5	40.6	32.1	56.5	2.9	1.028	4.2	61
Tonga	0.1	1.0	34.8	31.4	59.3	5.9	1.079	3.5	71
Trinidad and Tobago	1.4	0.4	20.1	19.4	68.4	11.5	1.040	1.7	74
Tunisia	11.8	1.1	24.3	20.8	66.8	8.9	1.054	2.2	77
Turkey	84.3	1.4	23.9	24.1	67.1	9.0	1.054	2.0	78
Turkmenistan	6.0	1.6	30.8	24.4	64.4	4.8	1.063	2.7	68
Turks and Caicos Islands	0.04	1.5	–	–	–	–	–	–	–
Tuvalu	0.01	1.2	–	–	–	–	1.068	–	–
Uganda	45.7	3.6	46.0	34.5	52.0	2.0	1.024	4.7	64
Ukraine[24]	43.7	-0.5	16.0	14.9	67.1	16.9	1.062	1.4	72
United Arab Emirates	9.9	1.3	14.8	15.8	83.9	1.3	1.050	1.4	78
United Kingdom[25]	67.9	0.6	17.7	17.3	63.7	18.7	1.055	1.7	81
United States of America[26]	331.0	0.6	18.4	19.5	65.0	16.6	1.047	1.8	79
United States Virgin Islands[13]	0.1	-0.1	19.3	19.6	60.2	20.5	1.039	2.0	81
Uruguay	3.5	0.4	20.3	21.1	64.6	15.1	1.051	2.0	78
Uzbekistan	33.5	1.6	28.8	24.6	66.4	4.8	1.078	2.4	72
Vanuatu	0.3	2.5	38.4	30.2	58.0	3.6	1.067	3.7	71
Venezuela (Bolivarian Republic of)	28.4	-1.1	27.3	25.5	64.8	8.0	1.054	2.2	72
Viet Nam	97.3	1.0	23.2	21.0	68.9	7.9	1.122	2.0	75
Western Sahara	0.6	2.5	27.2	24.9	69.4	3.4	1.050	2.3	71
Yemen	29.8	2.4	38.8	32.4	58.2	2.9	1.058	3.6	66
Zambia	18.4	2.9	44.0	34.3	53.9	2.1	1.013	4.5	64
Zimbabwe	14.9	1.5	41.9	33.2	55.1	3.0	1.023	3.5	62

NOTES

– Data not available.

1 For statistical purposes, the data for Netherlands do not include this area.

2 Including Christmas Island, Cocos (Keeling) Islands and Norfolk Island.

3 Including Nagorno-Karabakh.

4 For statistical purposes, the data for China do not include Hong Kong and Macao, Special Administrative Regions (SAR) of China, and Taiwan Province of China.

5 As of 1 July 1997, Hong Kong became a Special Administrative Region (SAR) of China. For statistical purposes, the data for China do not include this area.

6 As of 20 December 1999, Macao became a Special Administrative Region (SAR) of China. For statistical purposes, the data for China do not include this area.

7 Refers to the whole country.

8 For statistical purposes, the data for Denmark do not include Faroe Islands or Greenland.

9 Including Åland Islands.

10 For statistical purposes, the data for France do not include French Guiana, French Polynesia, Guadeloupe, Martinique, Mayotte, New Caledonia, Réunion, Saint Pierre and Miquelon, Saint Barthélemy, Saint Martin (French part) or Wallis and Futuna Islands.

11 For statistical purposes, the data for France do not include this area.

12 Including Abkhazia and South Ossetia.

13 For statistical purposes, the data for United States of America do not include this area.

14 Including Sabah and Sarawak.

15 Including Agalega, Rodrigues and Saint Brandon.

16 Including Transnistria.

17 For statistical purposes, the data for Netherlands do not include Aruba, Bonaire, Sint Eustatius and Saba, Curaçao or Sint Maarten (Dutch part).

18 For statistical purposes, the data for New Zealand do not include Cook Islands, Niue or Tokelau.

19 Including Svalbard and Jan Mayen Islands.

20 Including East Jerusalem.

21 Including Kosovo.

22 Including Canary Islands, Ceuta and Melilla.

23 Including Zanzibar.

24 Refers to the territory of the country at the time of the 2001 census.

25 Refers to the United Kingdom of Great Britain and Northern Ireland. For statistical purposes, the data for United Kingdom do not include Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Channel Islands, Falkland Islands (Malvinas), Gibraltar, Isle of Man, Montserrat, Saint Helena or Turks and Caicos Islands.

26 For statistical purposes, the data for United States of America do not include American Samoa, Guam, Northern Mariana Islands, Puerto Rico or United States Virgin Islands.

DEFINITIONS OF THE INDICATORS

Total population: Estimated size of national populations at mid-year.

Average annual rate of population change: Average exponential rate of growth of the population over a given period, based on a medium variant projection.

Population aged 0-14, per cent: Proportion of the population between age 0 and age 14.

Population aged 10-24, per cent: Proportion of the population between age 10 and age 24.

Population aged 15-64, per cent: Proportion of the population between age 15 and age 64.

Population aged 65 and older, per cent: Proportion of the population aged 65 and older.

Sex ratio at birth: Number of live male births per one live female birth.

Total fertility rate: Number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates.

Life expectancy at birth: Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.

MAIN DATA SOURCES

Total population: United Nations Population Division.

Average annual rate of population change: UNFPA calculation based on data from United Nations Population Division.

Population aged 0-14, per cent: UNFPA calculation based on data from United Nations Population Division.

Population aged 10-24, per cent: UNFPA calculation based on data from United Nations Population Division.

Population aged 15-64, per cent: UNFPA calculation based on data from United Nations Population Division.

Population aged 65 and older, per cent: UNFPA calculation based on data from United Nations Population Division.

Sex ratio at birth: Chao, F., Gerland, P., Cook, A. R., & Alkema, L. (2019). Systematic assessment of the sex ratio at birth for all countries and estimation of national imbalances and regional reference levels. Proceedings of the National Academy of Sciences of the United States of America, 116(27), 13700. https://doi.org/10.1073/pnas.1908359116

Total fertility rate: United Nations Population Division.

Life expectancy at birth: United Nations Population Division.

Technical notes

The statistical tables in the *State of World Population 2020* include indicators that track progress toward the goals of the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development (ICPD) and the Sustainable Development Goals (SDGs) in the areas of maternal health, access to education, and reproductive and sexual health. In addition, these tables include a variety of demographic indicators. The statistical tables support UNFPA's focus on progress and results towards delivering a world where every pregnancy is wanted, every birth is safe and every young person's potential is fulfilled.

Different national authorities and international organizations may employ different methodologies in gathering, extrapolating or analysing data. To facilitate the international comparability of data, UNFPA relies on the standard methodologies employed by the main sources of data. In some instances, therefore, the data in these tables differ from those generated by national authorities. Data presented in the tables are not comparable to the data in previous State of World Population reports due to regional classifications updates, methodological updates and revisions of time series data.

The statistical tables draw on nationally representative household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), United Nations organizations' estimates and inter-agency estimates. They also include the latest population estimates and projections from World Population Prospects: The 2019 revision, and Model-based Estimates and Projections of Family Planning Indicators 2020 (United Nations Department of Economic and Social Affairs, Population Division). Data are accompanied by definitions, sources and notes. The statistical tables in *State of World Population 2020* generally reflect information available as of March 2020.

Indicators for monitoring ICPD goals

Sexual and reproductive health and rights

Maternal mortality ratio (MMR) (deaths per 100,000 live births) and range of MMR uncertainty (UI 80%), lower and upper estimates.
Source: United Nations Maternal Mortality Estimation Inter-agency Group (MMEIG). MMR indicates the number of maternal deaths during a given time period per 100,000 live births during the same time period. The estimates are produced by the MMEIG using data from vital registration systems, household surveys and population censuses. UNFPA, WHO, The World Bank, UNICEF and United Nations Population Division are members of the MMEIG. Estimates and methodologies are reviewed regularly by the MMEIG and other agencies and academic institutions and are revised where necessary as part of the ongoing process of improving maternal mortality data. Estimates should not be compared with previous inter-agency estimates.

Births attended by skilled health personnel, per cent.
Source: Joint global database on skilled attendance at birth, 2020, UNICEF and WHO. Regional aggregates calculated by UNFPA based on data from the joint global database. Percentage of births attended by skilled health personnel (doctor, nurse or midwife) is the percentage of deliveries attended by health personnel trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; conducting deliveries on their own; and caring for newborns (SDG indicator 3.1.2). Traditional birth attendants, even if they receive a short training course, are not included.

Contraceptive prevalence rate, women aged 15–49, any method.
Source: United Nations Population Division. Percentage of women aged 15 to 49 who are currently using any method of contraception. Model-based estimates are based on data that are derived from sample survey reports. Survey data estimate the proportion of all women of reproductive age, and married women (including women in consensual unions), currently using any method of contraception.

Contraceptive prevalence rate, women aged 15–49, modern methods.
Source: United Nations Population Division. Percentage of women aged 15 to 49 who are currently using any modern method of contraception. Model-based estimates are based on data that are derived from sample survey reports. Survey data estimate the proportion of all women of reproductive age, and married women (including women in consensual unions), currently using any modern methods of contraception. Modern methods of contraception include female and male sterilization, the intra-uterine device (IUD), the implant, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), the lactational amenorrhea method, emergency contraception and other modern methods not reported separately.

Unmet need for family planning, women aged 15–49.
Source: United Nations Population Division. Percentage of women aged 15 to 49 who want to stop or delay childbearing but are not using a method of contraception. Model-based estimates are based on data that are derived from sample survey reports. Women who are using a traditional method of contraception are not considered as having an unmet need for family planning. All women or all married and in-union women are assumed to be sexually active and at risk of pregnancy. The assumption of universal exposure to possible pregnancy among all women or all married or in-union women may lead to lower estimates compared to the actual risks among the exposed. It might be possible, in particular at low levels of contraceptive prevalence, that when contraceptive prevalence increases, unmet need for family planning also increases. Both indicators, therefore, need to be interpreted together.

Proportion of demand for family planning satisfied by modern methods, women aged 15–49.
Source: United Nations Population Division. Percentage of total demand for family planning among women aged 15 to 49 that is satisfied by the use of modern contraception (SDG indicator 3.7.1). This indicator is calculated by dividing modern contraceptive prevalence by total demand for family planning. Total demand for family planning is the sum of contraceptive prevalence and unmet need for family planning.

Decision making on sexual and reproductive health and reproductive rights, per cent.
Source: UNFPA. Percentage of women aged 15 to 49 years who are married or in a union, who make their own decisions on three areas—their health care, use of contraception and sexual intercourse with their partners (SDG indicator 5.6.1).

Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent.
Source: UNFPA. The extent to which countries have national laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (SDG indicator 5.6.2).

Adolescents and youth

Adolescent birth rate per 1,000 girls aged 15–19.
Source: United Nations Population Division. Number of births per 1,000 adolescent girls aged 15 to 19 years (SDG indicator 3.7.2). The adolescent birth rate represents the risk of childbearing among adolescent girls aged 15 to 19 years. For civil registration, rates are subject to limitations which depend on the completeness of birth registration, the treatment of infants born alive but who die before registration or within the first 24 hours of life, the quality of the reported information relating to the age of the mother, and the inclusion of births from previous periods. The population estimates may suffer from limitations connected to age misreporting and coverage. For survey and census data, both the numerator and denominator come from the same population. The main limitations concern age misreporting, birth omissions, misreporting the date of birth of the child and sampling variability in the case of surveys.

Child marriage by age 18, per cent.
Source: UNICEF. Regional aggregates calculated by UNFPA based on data from UNICEF. Proportion of women aged 20 to 24 years who were married or in a union before the age of 18 (SDG indicator 5.3.1).

Female genital mutilation prevalence among girls aged 15–19, per cent.
Source: UNFPA. Proportion of girls aged 15 to 19 years who have undergone female genital mutilation (SDG indicator 5.3.2).

Adjusted net enrolment rate, primary education, per cent.
Source: UNESCO Institute for Statistics (UIS). Percentage of children of the official primary age group who are enrolled in primary and secondary education.

Gender parity index, primary education (2009–2019).
Source: UNESCO Institute for Statistics (UIS). Ratio of female to male values of adjusted primary school net enrolment ratio.

Net enrolment rate, secondary education, per cent (2009–2019).
Source: UNESCO Institute for Statistics (UIS). Percentage of children of the official secondary age group who are enrolled in secondary education.

Gender parity index, secondary education (2009–2019).
Source: UNESCO Institute for Statistics (UIS). Ratio of female to male values of secondary school net enrolment ratio.

Demographic indicators

Population

Total population in millions.
Source: United Nations Population Division. Estimated size of national populations at mid-year.

Population change

Average annual rate of population change, per cent.
Source: UNFPA calculation based on data from the United Nations Population Division. Average exponential rate of growth of the population over a given period, based on a medium variant projection.

Population composition

Population aged 0–14, per cent.
Source: UNFPA calculation based on data from the United Nations Population Division. Proportion of the population between age 0 and age 14.

Population aged 10–24, per cent.
Source: UNFPA calculation based on data from the United Nations Population Division. Proportion of the population between age 10 and age 24.

Population aged 15–64, per cent.
Source: UNFPA calculation based on data from the United Nations Population Division. Proportion of the population between age 15 and age 64.

Population aged 65 and older, per cent.
Source: UNFPA calculation based on data from the United Nations Population Division. Proportion of the population aged 65 and older.

Sex ratio

Sex ratio at birth, per female birth.
Source: Chao and others, 2019. "Systematic Assessment of the Sex Ratio at Birth for all Countries and Estimation of National Imbalances and Regional Reference Levels." *Proceedings of the National Academy of Sciences* 116(27); 13700. Number of live male births per one live female birth.

Fertility

Total fertility rate, per woman.
Source: United Nations Population Division. Number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates.

Life expectancy

Life expectancy at birth, years.
Source: United Nations Population Division. Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.

Regional classifications

UNFPA averages presented at the beginning of the statistical tables are calculated using data from countries and areas as classified below.

Arab States Region.
Algeria; Djibouti; Egypt; Iraq; Jordan; Lebanon; Libya; Morocco; Oman; Palestine; Somalia; Sudan; Syrian Arab Republic; Tunisia; Yemen.

Asia and the Pacific Region.
Afghanistan; Bangladesh; Bhutan; Cambodia; China; Cook Islands; Fiji; India; Indonesia; Iran (Islamic Republic of); Kiribati; Korea, Democratic People's Republic of; Lao People's Democratic Republic; Malaysia; Maldives; Marshall Islands; Micronesia (Federated States of); Mongolia; Myanmar; Nauru; Nepal; Niue; Pakistan; Palau; Papua New Guinea; Philippines; Samoa; Solomon Islands; Sri Lanka; Thailand; Timor-Leste, Democratic Republic of; Tokelau; Tonga; Tuvalu; Vanuatu; Viet Nam.

Eastern Europe and Central Asia Region.
Albania; Armenia; Azerbaijan; Belarus; Bosnia and Herzegovina; Georgia; Kazakhstan; Kyrgyzstan; Moldova, Republic of Serbia; Tajikistan; North Macedonia; Turkey; Turkmenistan; Ukraine; Uzbekistan.

East and Southern Africa Region.
Angola; Botswana; Burundi; Comoros; Congo, Democratic Republic of the; Eritrea; Eswatini; Ethiopia; Kenya; Lesotho; Madagascar; Malawi; Mauritius; Mozambique; Namibia; Rwanda; South Africa; South Sudan; Tanzania, United Republic of; Uganda; Zambia; Zimbabwe.

Latin America and the Caribbean Region.
Anguilla; Antigua and Barbuda; Argentina; Aruba; Bahamas; Barbados; Belize; Bermuda; Bolivia (Plurinational State of); Brazil; British Virgin Islands; Cayman Islands; Chile; Colombia; Costa Rica; Cuba; Curaçao; Dominica; Dominican Republic; Ecuador; El Salvador; Grenada; Guatemala; Guyana; Haiti; Honduras; Jamaica; Mexico; Montserrat; Nicaragua; Panama; Paraguay; Peru; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Sint Maarten; Suriname; Trinidad and Tobago; Turks and Caicos Islands; Uruguay; Venezuela (Bolivarian Republic of).

West and Central Africa Region.
Benin; Burkina Faso; Cameroon, Republic of; Cape Verde; Central African Republic; Chad; Congo, Republic of the; Côte d'Ivoire; Equatorial Guinea; Gabon; Gambia; Ghana; Guinea; Guinea-Bissau; Liberia; Mali; Mauritania; Niger; Nigeria; São Tomé and Principe; Senegal; Sierra Leone; Togo.

More developed regions are intended for statistical purposes and do not express a judgment about the stage reached by a particular country or area in the development process, comprising United Nations Population Division regions Europe, Northern America, Australia/New Zealand and Japan.

Less developed regions are intended for statistical purposes and do not express a judgment about the stage reached by a particular country or area in the development process, comprising all United Nations Population Division regions of Africa, Asia (except Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia.

The least developed countries, as defined by the United Nations General Assembly in its resolutions (59/209, 59/210, 60/33, 62/97, 64/L.55, 67/L.43, 64/295 and 68/18), included 47 countries (as of December 2018): 33 in Africa, 9 in Asia, 4 in Oceania and 1 in Latin America and the Caribbean—Afghanistan; Angola; Bangladesh; Benin; Bhutan; Burkina Faso; Burundi; Cambodia; Central African Republic; Chad; Comoros; Congo, Democratic Republic of the; Djibouti; Eritrea; Ethiopia; Gambia; Guinea; Guinea-Bissau; Haiti; Kiribati; Lao People's Democratic Republic; Lesotho; Liberia; Madagascar; Malawi; Mali; Mauritania; Mozambique; Myanmar; Nepal; Niger; Rwanda; São Tomé and Principe; Senegal; Sierra Leone; Solomon Islands; Somalia; South Sudan; Sudan; Tanzania, United Republic of; Timor-Leste; Togo; Tuvalu; Uganda; Vanuatu; Yemen; Zambia. These countries are also included in the less developed regions. Further information is available at http://unohrlls.org/about-ldcs/.

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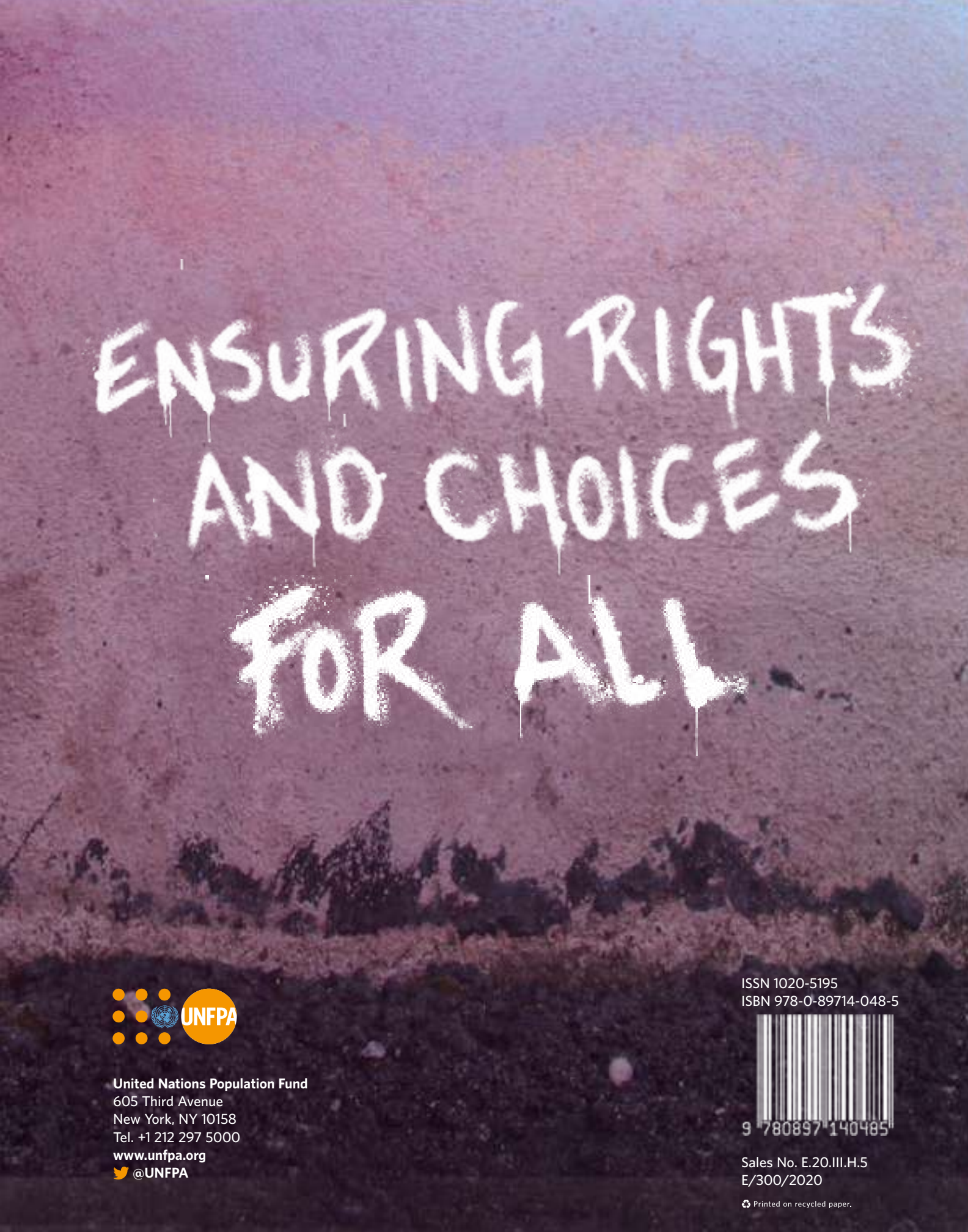

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ISSN 1020-5195
ISBN 978-0-89714-048-5

Sales No. E.20.III.H.5
E/300/2020

Printed on recycled paper.